MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03045

Reg. Dist. No. 3451

1. PLACE OF DEATH

County: Prince Georges.

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 802 Jackson Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: BEATRICE GUILD AYERS

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: George D. Ayers

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 9 1873

8. AGE: Years	Months	Days	If less than one day
74	2	4	..... hrs. ..... min.

9. Birthplace: Paris, France (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business:

FATHER

12. Name: Guild

13. Birthplace: Mass

MOTHER

14. Maiden name: Clerk Krone

15. Birthplace: unk.

16. Informant: Mrs James A Long

Address: 206 Spruce Ave Takoma Park

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: March 13 1947 (month) (day) (year)

Cemetery or crematory: J. Wm Lee's

Location: Washington D.C.

18. Funeral director: J. Williams Lee Sons Co.

Address: 309-4½ St N.E. Wash. D.C.

19. March 13 1947 (Date rec'd by registrar) Mabel A. Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1947 at 3:47 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 5 1946 to Mar 12 1947

and that I last saw h Sr alive on 3/12/47 19.....

Immediate cause of death	DURATION
Valvular heart disease + pulmonary congestion	19 yrs.
Due to: Rheumatic fever (Orig.) (Pulmonary Edema)	1 week
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John Warren Asst M.E. M. D. or other

Address: 5022 Reno Rd. N.W. Date signed: 3/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-2450 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03046

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 2 mos., 6 days.

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 2 mos., 6 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 126 C. St., S. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Badgett, Annie Mae

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: James H. Badgett

6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1925

8. AGE: Years	Months	Days	If less than one day
22	1	3	hrs. min.

9. Birthplace: Washington Co., North Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: - -

FATHER
12. Name: ?
13. Birthplace: ? , North Carolina

MOTHER
14. Maiden name: Mary Wells
15. Birthplace: ? , North Carolina

16. Informant: Deceased
Address

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof: Apr. 1, 1947
(month) (day) (year)

Cemetery or crematory:
Location: to Washington, D.C.

18. Funeral director: John F. Rhines & Co.
Address: 981-3rd St. S.W.

19. Mar. 31, 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31, 1947, at 1:35 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/24 1946 to 3/31 1947 and that I last saw h[illegible] alive on 3/31 1947

Immediate cause of death	DURATION
(a) Pulm. Tuberculosis	18 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: Mar 31, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of Age is shown on Film D109. 3/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (934)

CERTIFICATE OF DEATH

★ 03047

Reg. Dist. No. 2465

1. PLACE OF DEATH:
County: Prs Georges Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 2 months
Hospital, institution, or street address where death occurred: Mother Jones Rest Home
How long in hospital or institution? 1 yr 2 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prs Geo Co
City or town: Forestville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8000 Bone Lane Washington 19. DC
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rozella Baldwin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Victor E. Baldwin
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec 26, 1864

8. AGE: Years	Months	Days	If less than one day
82 83	3	—	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Frank Richardson
13. Birthplace: Md
MOTHER 14. Maiden name: Rachel Cyles
15. Birthplace: Md
16. Informant: Victor E. Baldwin Jr.
Address: Forestville Md
17. Burial: Mar 17, 1947 Date thereof (month) (day) (year)
(Burial, cremation, or removal. Which?)
Cemetery or crematory: Forestville Episcopal Cemetery
Location: Forestville Md.
18. Funeral director: F Kosche Sons
Address: Hyattsville Md.
19. March 15 19 47 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14, 1947, at 8 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946, to March 14 1947 and that I last saw her alive on March 11 1947

	DURATION
Immediate cause of death: Abdominal Sepsis	2 days
Due to: Senility	Several Years
Due to: Chronic Hypertension & Arteriosclerosis	Several Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Wm Allen Griffith M. D. or other
Address: Berwyn Md Date signed 4/14/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1—25—

2—2450 — 7-10

Evidence for the additon of birth date is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03048

FILM No. G 109 APR 17 1947

Reg. Dist. No. 2430

1. PLACE OF DEATH:
County: Prince George
City or town: Bowie (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 63 years
Hospital, Institution, or street address where death occurred: Home - Bowie Md
How long in hospital or institution? Not at All

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Bowie (If outside city or town limits, write RURAL and give nearest town)
Street No. Bowie (If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: JAMES SAMUEL BANKS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Negro	Married

6.(b) Name of husband or wife: Cora Virginia Banks
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): December 17, 1863

8. AGE: Years 68 Months 8 Days July 11, 1878 If less than one day ... hrs. ... min.

9. Birthplace: Washington, DC (Town, county, and state)
10. Usual occupation: Butcher
11. Industry or business: Produce
FATHER 12. Name: Jacob I Banks
13. Birthplace: Caroline County, Va
MOTHER 14. Maiden name: Mildred J. Banks
15. Birthplace: King George County, Va.
16. Informant: Coldie Jackson
Address: 436 N. Jonathan, Hagerstown, Md
17. Buried (Burial, cremation, or removal, Which?) Date thereof: 3-20-47 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Pleasant Grove, Bowie
18. Funeral director: Emanuel Floding Sons
Address: Bowie, Md.
19. Mar. 19 1947 (Date rec'd by registrar) Mrs. J. W. Gingling Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1947 at 4: A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9th, 1947 to March 14th 1947 and that I last saw h. I m. alive on March 14th, 1947

Immediate cause of death	DURATION
Congestive Heart failure	9 months
Due to: Hypertension	8-10 yrs
Due to:	
Other conditions: Renal Failure (Chronic Glomerulitis)	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: John B. Lyons Jr M.D.
M. D. or other
Address: Bowie, Maryland Date signed: 3-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

*03049

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town Hyattsville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, institution, or street address where death occurred:
5002 - 46th Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5002 - 46th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Walter Thomas Barton Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Widowed

6.(b) Name of husband or wife Elizabeth Barton deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 15 1903

8. AGE: Years	Months	Days	If less than one day
44			..... hrs. ..... min.

9. Birthplace Prince Georges Co., (Town, county, and state)
10. Usual occupation Laborer, Cinder Block
11. Industry or business Cinder Bl. Factory
FATHER 12. Name Walter T. Barton Sr.
13. Birthplace P. Georges Co.
MOTHER 14. Maiden name Sophia Barton
15. Birthplace P. Georges Co.
16. Informant Ella Thomas Mangles
Address 4712 - 41st. Pl. Hyattsville Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof March 24 1947 (month) (day) (year)
Cemetery or crematory
Location 467 N St. N.W. Wash. D.C.
18. Funeral director Henry S. Washington & Son + Sons
Address 467 N St. N.W.
19. March 24 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947 at 7:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 13, 1946 to March 23 1947 and that I last saw h— alive on March 22 1947

Immediate cause of death	DURATION
Myocarditis Acute.	1 wk.
Due to Age, work and	
Due to Possible Chronic Bronchitis	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William H. Spilly M.D. M. D. or other
Address Brentwood Md. Date signed 3/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03050

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one month, 29 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? one month, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 52 DeFrees St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: BATSON HELEN

3. (b) Social Security Number: 579-12-1777

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	Colored	Separated

6.(b) Name of husband or wife: Oscar Batson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 17, 1909

8. AGE:	Years	Months	Days	If less than one day
	38	1	6	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Laundress

11. Industry or business: Laundry

FATHER
12. Name: Ernest W. Gatewood
13. Birthplace: ? Maryland

MOTHER
14. Maiden name: Louise Dutch
15. Birthplace: Montgomery Co., Maryland.

16. Informant: Deceased
Address

17. (Burial, cremation, or removal. Which?) Removal Date thereof: 3/24/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: J. P. Sherman

Address: 8 O H St NE

19. Mar. 23, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/23 1947, at 6 10 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/23 1947 to 3/23 1947 and that I last saw h... alive on 3/23 1947

Immediate cause of death	DURATION
pulm. tuberculosis	20 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: Mar. 23, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

03051

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Prince Georges General
How long in hospital or institution? 16 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3805 - 31st St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Shelby M Baylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jeannette Baylor
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 27 1899

8. AGE: Years	Months	Days	If less than one day
48	0	4	..... hrs. ..... min.

9. Birthplace: Luray, Page, Virginia (Town, county, and state)
10. Usual occupation: Stock room manager
11. Industry or business

FATHER
12. Name: David Baylor
13. Birthplace: Luray Virginia

MOTHER
14. Maiden name: Minnie Pratt
15. Birthplace: Luray Virginia

16. Informant: Jeannette Baylor
Address: 3805-31st St. Mt. Rainier Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/3/47 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Bladensburg Rd. & D.C. Line Md.

18. Funeral director: Wm. J. Malley
Address: 3200-R.I. Ave. Mt. Rainier Md.

19. 4/3 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-31- 1947 at 6:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-25 1947, to 3-31 1947
and that I last saw h[illegible] alive on 3-31 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	3½ days
Due to: Hypertensive Cardio-Vascular Disease	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: Mt. Rainier Md. Date signed 4-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

CERTIFICATE OF DEATH

03052

Reg. Dist. No. 234

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Piscataway
(If outside city or town limits, write RURAL, NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr George
City or town: Piscataway Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: C/o Fred Hubbard
(If rural give LOCATION)
2(a) IF YETERAN, NAME WAR:

3. (a) FULL NAME Elizabeth Virginia Baden

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife: George Baden
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9, 1853

8. AGE:

Years	Months	Days	If less than one day
93	11	14	hrs. min.

9. Birthplace: Odenville, Md
(Town, county, and state)
10. Usual occupation: Farmers Wife
11. Industry or business
FATHER 12. Name: Henry Coates
13. Birthplace: Odenville, Md
MOTHER 14. Maiden name: Evelyn
15. Birthplace: Odenville, Md.
16. Informant: Mrs Fredrick T. Uncle
Address: Piscataway, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/27/47 (month) (day) (year)
Cemetery or crematory: St. Mary's
Location: Piscataway, Md.
18. Funeral director: Hewitt & Kyton
Address: Waldorf, Md.
19. 3/25 1947 Mrs. Alton Davis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 1947, at 1:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1947 to Mar 21 1947, and that I last saw h[illegible] alive on March 23 1947.

	DURATION
Immediate cause of death: Myocarditis	
Congestive Heart Failure	
Due to: Arteriosclerosis	20 yr
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E. W. Schwartz MD
1225 Talbert St SE
Address: Wash (20) DC
M. D. or other
Date signed 3/25/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

03053

Reg. Dist. No. 7450

1. PLACE OF DEATH:
County: Prince Georges Co.
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Six months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4613 - 47th St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alberta Boswell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Wh	Widowed

6.(b) Name of husband ~~or wife~~: John E Boswell
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): ~~1865~~ 5-1-1872

8. AGE: Years: 74 | Months: 10 | Days: 20 | If less than one day: ____ hrs. ____ min.

8. Birthplace: Savage Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: William Tucker
13. Birthplace: England

MOTHER
14. Maiden name: Amelia Henrietta Schultz
15. Birthplace: Germany

16. Informant: Daughter, Mrs. Crawford
Address: 4613 - 47th St. Mt. Rainier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-25-47 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Washington D.C.
18. Funeral director: W. W. Chambers Co.
Address: 5801 Cleveland Ave. Rivr. Md.
19. March 29 1947 James Seney (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 21 1947, at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 9 1947, to Mar. 21 1947
and that I last saw her alive on Mar. 21 1947

	DURATION
Immediate cause of death: Cerebral Thrombosis	12 days
Due to: Arterio-sclerotic hypertensive heart disease	15 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Irvin M. Grassgreen, M.D.
M. D. or other
Address: 2503 Queens Chapel Rd. Mt. Rainier, Md. Date signed: 3-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

★ B 03054

Reg. Dist. No. 24 5

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 715 Jackson St. N E
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Mary Jeanette Bowles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Franklin Bowles
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 23, 1869

8. AGE: Years: 78 | Months: 1 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: St. Mary's County, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Joseph Hugh Raley
13. Birthplace: St. Mary's County, Md

MOTHER
14. Maiden name: Anne Mary Dyson
15. Birthplace: St. Mary's County, Md.

16. Informant: Leland Memorial Hospital Records
Address: Riverdale, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/31/1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.

18. Funeral director: Robert J Mattingly
Address: 1311 11th St. S.E. Washington D.C.

19. March 29 1947 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28 19 47 at 7 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 25 19 47, to Mar. 28 19 47
and that I last saw h[illegible] alive on 19

Immediate cause of death	DURATION
Acute cardiac failure	3 days
Due to: Cardiovascular renal disease	—
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Earl N. Graff, M.D. (M. D. or other)
Address: 3400 24th St NE Date signed: 3/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

Evidence for the change of age is shown on G 109 3/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5D)

CERTIFICATE OF DEATH

03055

Reg. Dist. No. 2350

1. PLACE OF DEATH:
County Pr. Geo. Co.
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pr Geo Co
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4615 Emerson St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jennie S. Bray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Wm W. Bray
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 28 - 1871

8. AGE: Years	Months	Days	If less than one day
69			____ hrs. ____ min.

9. Birthplace Keith, Aberdeen Co., Va
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Isaac Bray
13. Birthplace Va
MOTHER 14. Maiden name Jennie Bray
15. Birthplace Va
16. Informant Edwin W. Bray
Address 3372 - 17 St SE.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 24-47 (month) (day) (year)
Cemetery or crematory Ft. Lincoln Cem.
Location Wash. D.C.
18. Funeral director Wm Clements Co
Address 511-11 St SE
19. Mar 20 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 20 1947, at 830 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-20-46 19__, to 3-20-47 1947
and that I last saw her alive on 3-20-47 19__

Immediate cause of death	DURATION
Carcinoma of breast	18 Mo
Due to carcinomatosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John P. Clum M.D.
M. D. or other
Address Hyattsville Md Date signed 3-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B6)

CERTIFICATE OF DEATH

S★ 03056

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1107 W. Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ERNESTINE O. BROWN

3.(b) Social Security Number: - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 20, 1919

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
28	1	19		

9. Birthplace: Monroeville, Alabama
(Town, county, and state)

10. Usual occupation: Clerk, O.P.A.,

11. Industry or business:

FATHER — 12. Name: Joseph Brown

FATHER — 13. Birthplace: Monroeville, Alabama

MOTHER — 14. Maiden name: Viola Nettles

MOTHER — 15. Birthplace: Monroeville, Alabama

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 3/10/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington D. C.

18. Funeral director: Allen + Marvin Inc.

Address: 1326 - Vea St. N. W.

19. Mar 9, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9th 1947, at 8:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 8th 1946, to March 9th 1947

and that I last saw her alive on March 9th 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: David Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md., Date signed: 3/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124)

CERTIFICATE OF DEATH

03057

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred: Prince Georges Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: College Heights Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Shady Side Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James S. Bryan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 8, 1874

8. AGE: Years 72 | Months 2 | Days 29 | If less than one day: hrs. min.

9. Birthplace: Bryans Point, Md.
(Town, county, and state)

10. Usual occupation: Retired Fisherman

11. Industry or business: None

MOTHER FATHER
12. Name: George Bryan
13. Birthplace: Saint Mary's
MOTHER
14. Maiden name: Hannah Barry
15. Birthplace: Maryland

18. Informant: Mrs. Orpha Bryan
Address: 6315 - 14th St. N.W. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-8-47 (month) (day) (year)
Cemetery or crematory: Congressional
Location: Cheverly, Md.

18. Funeral director: Peter Bros
Address: Upper Marlboro, Md.

19. 3/8 1947 (Date rec'd by registrar) Amanda Lowery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1947, at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1, 1947 to March 7, 1947
and that I last saw h... alive on ..., 19...

Immediate cause of death: Congestive heart failure — DURATION: One week
Due to: Cirrhosis of liver — Years
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. A. Pagar M. D. or other
Address: Seat Pleasant, Md. Date signed: March 8 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03058

CERTIFICATE OF DEATH

Reg. Diat. No.....

1. PLACE OF DEATH:
County PRINCE GEORGES
City or town LAUREL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County CARROLL
City or town MT. AIRY
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CARROLL F. BURDETTE

3.(b) Social Security Number 705 - 12- 5789

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: GOLDEN L. BURDETTE

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 16, 1903

8. AGE: Years	Months	Days	If less than one day
43	4	27	..... hrs. ..... min.

9. Birthplace: MARYLAND
(Town, county, and state)

10. Usual occupation: TRACKMAN B & O RR

11. Industry or business

FATHER
12. Name: FRANK BURDETTE
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: AMANDA BELLISON
15. Birthplace: MARYLAND

16. Informant: MRS. GOLDEN L. BURDETTE
Address: MT. AIRY MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-16-47 (month) (day) (year)
Cemetery or crematory: PINE GROVE
Location: MT. AIRY CARROLL CO. MD.

18. Funeral director: C. M. WALTZ
Address: WINFIELD MARYLAND

19. 3-16-47 (Date rec'd by registrar) 19..... Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 1947 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-13-47 19..... to ..... 19.....
and that I last saw him alive on March 13, 1947 19.....

Immediate cause of death	DURATION
CORONARY THROMBOSIS	1 day
Due to: UNKNOWN	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

SIGN HERE 23. SIGNATURE J. M Warren M.D.
M. D. or other
Address Laurel Md. Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-B)

CERTIFICATE OF DEATH

03059

Reg. Diat. No. 2420

1. PLACE OF DEATH:
County: Prince Georges
City or town: Inglewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, Institution, or street address where death occurred: 6018 Sheriff Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State Maryland County Prince Georges
City or town: Inglewood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6018 Sheriff Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Edward Burroughs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Ida E. Burroughs
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): June 23, 1889

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
57	8	19		

9. Birthplace: Charles County, Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Charles County, Md.

MOTHER
14. Maiden name: Emily ?
15. Birthplace: Charles County, Md.

16. Informant: Mrs. Ida E. Burroughs
Address: 6018 Sheriff Road

17. Removed (Burial, cremation, or removal. Which?) Date thereof March 19, 1947 (month) (day) (year)
Cemetery or crematory
Location: Washington, D.C.

18. Funeral director: John T. Stewart
Address: 3d St. NE.

19. 3/19 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19, 1947 at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945, to March 19 1947 and that I last saw h.. alive on March 19 1947

Immediate cause of death: Congestive Heart Failure and Cerebral Accident — DURATION: 30 min.
Due to: Hypertensive Cardio-Vascular Disease with Mitral — unknown
Due to: Insufficiency
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: John L. Robinson, M.D.
M. D. or other
Address: 1001 Eastern Ave. NE. Date signed: 3/19/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20a)

CERTIFICATE OF DEATH

03060

Reg. Dist. No. 231 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 14 hours 35 Min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6204 54th ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Butler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Beatrice

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 19 - 1887

8. AGE: Years	Months	Days	If less than one day
60	3	3	..... hrs. ..... min.

9. Birthplace: South America (Town, county, and state)

10. Usual occupation: Dentist

11. Industry or business

FATHER

12. Name: George Butler

13. Birthplace: Georgia

MOTHER

14. Maiden name: Edna Dumphrey

15. Birthplace: North Carolina

16. Informant: Beatrice V. Butler

Address: 6204 54th Ave Riverdale, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof March 22, 47 (month) (day) (year)

Cemetery or crematory: Washington D.C.

Location

18. Funeral director: Martin W. Nysong Co.

Address: 300 N. Street, N.W. Wash. D.C.

19. 3/22 1947 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-22 1947, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1946, to March 22 1947

and that I last saw h... alive on March 1 1947

Immediate cause of death	DURATION
Auto Heart failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Hyattsville Md. Date signed 3-22-47

#401 Balls ar
Lu Downey

1-55-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

03061

CERTIFICATE OF DEATH

Reg. Diat. No. 2340

1. PLACE OF DEATH:
County: Prince George
City or town: (Rural) Accokeek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Approx - 90 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George
City or town: Rural (Accokeek)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Carter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Widowed

6.(b) Name of husband or wife: Martha Banks Carter.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Not Known

8. AGE: Years: Approx. 90 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Prince George Co. Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farm.

FATHER
12. Name: Not Known
13. Birthplace

MOTHER
14. Maiden name: Not Known
15. Birthplace

16. Informant: Bertha Savage
Address: Accokeek. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March. 8, 1947 (month) (day) (year)
Cemetery or crematory: M.E.
Location: Pomunkey Md
18. Funeral director: Hunt & Ryan
Address: Waldorf. Md

19. 3-7 (Date rec'd by registrar) 19 47 H. L. Monroe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 19 47 at 5-12 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5 19 47 to March 5 19 47 and that I last saw h.. alive on Feb. 20 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	3yrs.
Due to	
Due to	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Franklin Susanka M. D. M. D. or other
Address: Indian Head Md Date signed 3-5-47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

S 03062

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George's
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 101 days
Hospital, institution, or street address where death occurred: Prince George's General Hospital
How long in hospital or institution? 101 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1921 Kearney St. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charters, Mrs. Anna M

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.): Dec. 5 1852
8. AGE: Years 94 | Months | Days | If less than one day ....hrs. ....min.
9. Birthplace: Pennsylvania
(Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Jacob Hartstein
13. Birthplace: Germany
MOTHER 14. Maiden name: Christina Heller
15. Birthplace: Germany
16. Informant: Margaret Charters
Address: 1921 Kearney St N.E. D.C.
17. Burial Date thereof: Mar. 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Hayes Cemetary
Location: Wayne, Ohio.
18. Funeral director: The S. H. Hines Co
Address: 2901 14th St. N.W.
19. 3/8 1947 Amanda Dauney, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-7 1947 at 11:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19.... to .... 19....
and that I last saw h.... alive on .... 19....

Immediate cause of death: Purulent cystitis with pyelitis

DURATION

Due to
Due to: Fracture of left hip
Other conditions: Hypostatic pneumonia
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results: Same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 11-26-46
Where did injury occur? Washington D.C.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) On street
Means of injury: Slipped and fell to pavement
Deputy medical examiner
23. SIGNATURE: [illegible] M.D. or other
Address: Forestville Md. Date signed 3-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Since this accident happened in the District of Columbia the District Coroner Dr. A. Magruder MacDonald has been notified and this case is released with his approval

James J. Doyle

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

CERTIFICATE OF DEATH

03663

Reg. Diat. No. 2370

1. PLACE OF DEATH:
County: Prince George's
City or town: Aquasco
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Aquasco
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Bruce Chesley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years: 80 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Aquasco, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farmer

FATHER
12. Name: Charles Edelen
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ellen Chesley
15. Birthplace: Maryland

16. Informant: John H. Chesley
Address: Aquasco, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-2-47 (month) (day) (year)
Cemetery or crematory St Putus
Location Waldorf Md.

18. Funeral director: Hunt & Ryon
Address Waldorf Md.

Issued by M. L. Howard

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30, 19 47 at 8:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Shock	
Due to: Universal 3rd degree burns of entire body	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 3/30/47
Where did injury occur? Aquasco (City or town) P.G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Occupant of house that burned down.

Deputy Medical Examiner

23. SIGNATURE: [signature] M. D. or other
Address: Forestville, Md. Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B3a)

CERTIFICATE OF DEATH

Reg. Dist. No. 03064 (2834)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: 4434 St Barnabas Rd S.E.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
none
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: ~~4434~~ Rural - Silver Hill Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4434 St Barnabas Rd S.E.
(If rural, give LOCATION)
Washington D.C.
2.(a) If veteran, name war:

3.(a) FULL NAME Lilly L. Clifton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	white	married

B.(b) Name of husband or wife: Wm E Clifton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 10th 1885

8. AGE: Years: 62 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: William H. Moore
13. Birthplace: Virginia

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: William E. Clifton
Address: 4434 St. Barnabas Rd., Washington 20 D.C.

17. (Burial, cremation, or removal. Which?) Buried Date thereof: March 30 1947 (month) (day) (year)
Cemetery or crematory: St. Barnabas Cemetery
Location: Oxon Hill, Md.

18. Funeral director: Thos. E. Murray Funeral Home
Address: 2007 Nichols Ave S.E. Washington (20) D.C.

19. March 27 1947 (Date rec'd by registrar) Harold J. Beach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1947 at 7.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1947, to March 27 1947
and that I last saw her alive on March 27 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: Generalized Arteriosclerosis	Unknown
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Paul E Tarlton M. D. or other
Address: 5440 Silver Hill Road Washington 20 D.C. Date signed: Mar 28 1947

2-25

2-2340 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

03665

Reg. Dist. No. 2310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Avondale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Avondale Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4 Avon Circle
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Vessie Clara Cole

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John McLane Cole
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 4 1883.

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER — 12. Name: Hawley G. Baxter
13. Birthplace: Mass
MOTHER — 14. Maiden name: Clara Koon
15. Birthplace: Mass
16. Informant: Frank McLane Cole
Address: 4 Avon Circle
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 10, 1947 (month) (day) (year)
Cemetery or crematory: Ft Lincoln
Location: Bladensburg Md
18. Funeral director: Deal Funeral Home
Address: 4812 Ga Ave NW D.C.
19. 3/7 (Date rec'd by registrar) 1947 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/6 1947 at 7 p. m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1945 to 3/6 1947
and that I last saw her alive on 3/6 1947

Immediate cause of death	DURATION
Coronary sclerosis	
Due to: arteriosclerosis	
Due to:	
Other conditions: angina pectoris	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T Barnes M.D.
M. D. or other
Address: 1835 I St. NW Date signed: 3/7/47

Dr Jane T. Burns
1835 Eyeman Rd

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03066

Reg. Diat. No. 2310

1. PLACE OF DEATH:
County Prince George's
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2703 Lake Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eugene C. Colgan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret M. Colgan
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): July 7, 1900

8. AGE: Years	Months	Days	If less than one day
46			hrs. min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: U. S. Government
FATHER 12. Name: Christopher Colgan
13. Birthplace: Ohio
MOTHER 14. Maiden name: Bridgett O'Mara
15. Birthplace: Ireland
16. Informant: Margaret M. Colgan
Address: 2703 Lake Ave., Cheverly, Md.
17. Transportation (Burial, cremation, or removal. Which?) Date thereof 3-17-47 (month) (day) (year)
Cemetery or crematory: St. Mary's
Location: Elysia, Ohio
18. Funeral director: J. Gaeche's Sons
Address: Hyattsville, Md.
19. 3/17 1947 (Date rec'd by registrar) Amanda Deeney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1947 at 3:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Deputy medical Examiner
23. SIGNATURE: [illegible] M. D. or other
Address: [illegible] Date signed 3-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3rd)

CERTIFICATE OF DEATH

03667

★ Reg. Dist. No. 2310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prs Geo Co
City or town: Colmar Manor Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prs Geo Co
City or town: 3308 - 40th Ave.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Colmar Manor Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Abraham Conway

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie M. Conway
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): March 17, 1878

8. AGE: Years: 68 | Months: 11 | Days: 25 | If less than one day: ...hrs. ...min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Laborer-
11. Industry or business: Town trash Collector

FATHER
12. Name: Charles Conway
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Jennie Stepherd
15. Birthplace: Washington D.C.

16. Informant: James Conway
Address: Colmar Manor Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 14, 1947 (month) (day) (year)
Cemetery or crematory: Glenwood Cemetery
Location: Washington D.C.

18. Funeral director: F Gaschs Sons
Address: Hyattsville Md.

19. 3/13/47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 19 47 at 12½ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 19 46, to Present 19 ...
and that I last saw h...alive on Feb. 22 19 47

Immediate cause of death	DURATION
Acute pulmonary edema	
Due to Congestive heart failure	4 mos. (known)
Due to Coronary sclerosis with myocardial degeneration	4 mos. (known)
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Julius Kauffman M.D.
M. D. or other
Address: 5423 Annapolis Rd. Bladensburg, Md. Date signed: 3/12/47

Coroner notified. Will approve

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1a)

CERTIFICATE OF DEATH

03668

★ Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Maryland Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Years

Hospital, Institution, or street address where death occurred:

104 - 64th Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Maryland Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 104 - 64th Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Ferdinand Cox

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Catherine Mahoney Cox

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 19, 1875

8. AGE: Years	Months	Days	If less than one day
71	3	24	..... hrs. ..... min.

9. Birthplace: Washington DC

(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Building

FATHER — 12. Name: George Ferdinand Cox

FATHER — 13. Birthplace: Washington, D.C.

MOTHER — 14. Maiden name: Jennie Cox

MOTHER — 15. Birthplace: Washington DC

16. Informant: Mrs. Stella Spring

Address: 914 - 10th St N.W., Wash D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-17-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland, Md.

18. Funeral director: W. W. Chambers Co.

Address: 517 11th St S.E.

19. March 15 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1947, at 5:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner James A. Ford M. D. or other

Address: Westville Md. Date signed 3-13-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

CERTIFICATE OF DEATH

03069

Reg. Dist. No. 2421

1. PLACE OF DEATH:
County Prince George's
City or town Rosaryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Rosaryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Jennie Cornelia Crane

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Charles Crane
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1856

8. AGE: Years	Months	Days	If less than one day
90			hrs. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Stephen Miller
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Mary A. Stark
15. Birthplace Pennsylvania

16. Informant Lt. Col. John S. Crane
Address Rosaryville, Md.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Wash. D.C. 3/15/47
Location
18. Funeral director T. F. Costello
Address 1722 North Capitol St.
19. 3/15 1947 (Date rec'd by registrar) Thos E. Hall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 47, at 8:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James V. Boyd M. D. or Coroner
Address Forestville, Md. Date signed 3-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1-25

2-2420 —— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03070

Reg. Dist. No. 246

1. PLACE OF DEATH:

County: Prince George's

City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: P. G.

City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)

Street No.: District Training School (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Cunningham, Mrs. Nell (SHRIVER)

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: LeRoy Cunningham

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1881

8. AGE: Years	Months	Days	If less than one day
65	3	9	..... hrs. ..... min.

9. Birthplace: Martinsburg, W. Va. (Town, county, and state)

10. Usual occupation: Matron

11. Industry or business: Dist. of Columbia Training School

FATHER — 12. Name: Peter J. Shriver

FATHER — 13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Susan Jane Spring

MOTHER — 15. Birthplace: W. Va.

16. Informant: Mr. Roy S. Cunningham

Address: 1624 N. Calvert St.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 3/6/47 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore, Md.

18. Funeral director: WM. J. TICKNER & SONS INC.

Address: North & Pa Aves. Balto. 17, Md.

19. March 6 19 47 (Date rec'd by registrar) A. W. Fedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 19 47, at 8 00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 25 19 47, to March 3 19 47

and that I last saw him alive on March 3 19 47

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to	
Due to	
Other conditions: Myocardial Insufficiency (Include pregnancy within 3 months of death)	3 mo

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. B. Johnson M. D. or other

Address: ..... Date signed 3-4-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Land 680

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

03671

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Capt. Hgts, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, institution, or street address where death occurred:
829-59th Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 829 59th ave
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: GEORGE WILLIAM CURTIN

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Pearl E. Curtin
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): Dec. 29th 1879
8. AGE: Years: 67 Months: 2 Days: 26 If less than one day: ..... hrs. ..... min.
9. Birthplace: Washington, D.C. (Town, County, and state)
10. Usual occupation: Retired (Painter)
11. Industry or business: none
FATHER 12. Name: Marion J. Curtin
13. Birthplace: Maryland
MOTHER 14. Maiden name: Kate T. Cohen
15. Birthplace: Maryland
16. Informant: Mrs Pearl E. Curtin
Address: 829 59th Ave. Capt. Hgts. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-28-47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.
18. Funeral director: W. W. Chambers Co.
Address: 517 11th St. S.E. DC
19. March 25 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25th 1947 at 3:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Congestive heart heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Deputy medical examiner
M.D. or other
Address: Washington, D.C. Date signed: 3-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (no-C.)

03073

CERTIFICATE OF DEATH

Reg. Dist. No. 231

MV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hrs

Hospital, Institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Bladensburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 4907 Duncan Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Henry A. Dalley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 27, 1927

8. AGE: Years: 19 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Bladensburg, Md. (Town, county, and state)

10. Usual occupation: Truck Farmer

11. Industry or business

FATHER — 12. Name: William Dalley

FATHER — 13. Birthplace: Washington D.C.

MOTHER — 14. Maiden name: Susan Taylor

MOTHER — 15. Birthplace: Washington D.C.

16. Informant: William Dalley

Address: 4907 Duncan Street, Bladensburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 4, 1947 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln

Location: Washington D.C.

18. Funeral director: F. Beadie sons

Address: Hyattsville Md.

19. 3/2 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1, 1947, at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	
Shock	
Due to Fractured Skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? accident Date of 2-28-47

Where did injury occur? Bladensburg P.G. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? Bladensburg Highway

Means of injury: Pedestrian struck Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other

Address: Forestville Md. Date signed: 3-1-47

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

03072

Reg. Dist. No. 2451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County: Green
City or town: Leeds
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Church Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: WILLIAM CROPSY DE NYSE

3. (b) Social Security Number: 054-16-1935

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret H. De Nyse
6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): June 23, 1884.

8. AGE: Years	Months	Days	If less than one day
62	9	5	..... hrs. ..... min.

9. Birthplace: Staten Island, New York (Town, county, and state)
10. Usual occupation: Watchman,
11. Industry or business: White Hall Hotel Fla.
FATHER 12. Name: William C. De Nyse
13. Birthplace: New York
MOTHER 14. Maiden name: Frances Evans
15. Birthplace: New York
16. Informant: Charles Reilly
Address: 61 Cottage Street, Jersey City,
17. (Burial, cremation, or removal, Which?) March 29, 1947 Date thereof: Burial (month) (day) (year)
Cemetery or crematory: Holy Cross Cemetery
Location: North Arlington, New Jersey
18. Funeral director: W.W. Chambers Company
Address: 5801 Cleveland Ave., Riverdale, Md.
19. (Date rec'd by registrar) March 29 1947 Mrs Jas Severn Registrar Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28 1947, at 5 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	
and Shock	
Due to Crushed chest	
Sub-arachnoid hemorrhage.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Given above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 3-26-47
Where did injury occur? Mundith (City or town) P.G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Route #1
Means of injury: Struck by car in collision with truck while at work
Deputy Medical Examiner
23. SIGNATURE: Harvey D. Ford M. D. or other
Address: Forestville Md Date signed 3-28-47

1-25

2-2450-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03074

Reg. Dist. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 8-45-15M

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 YR.; 10 M.; 8 D
Hospital, Institution, or street address where death occurred: Laurel Sanitarium
How long in hospital or institution? 3 Yrs.; 10 M.; 8 D

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5515 Eldorado Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Madeline Davis Dow

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Bernard Dow
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 7 - 1884

8. AGE: Years: 62 | Months: 10 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Mass.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER
12. Name: Walter E. Davis
13. Birthplace: Mass.

MOTHER
14. Maiden name: Mary Perry Sweet
15. Birthplace: Mass

16. Informant: Sanitarium Records
Address: Laurel San., Laurel, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 14th 1947 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: " Md.

18. Funeral director: Wm Cook Inc.
Address: 1217 St. Paul St.

19. Mar 15 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1947 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1943, to March 13 1947, and that I last saw h[illegible] alive on March 13 1947

Immediate cause of death	DURATION
Bronchopneumonia	3/5/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John L. Wetherald M.D. M. D. or other
Address: Laurel San., Laurel, Md. Date signed: 3/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

03075

Reg. Diat. No. 2420

1. PLACE OF DEATH:
County PRINCE GEORGE
City or town 5311- 2nd ST. CORAL HILL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 YEARS
Hospital, Institution, or street address where death occurred:
5311- 2nd ST CORAL HILL
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County PRINCE GEORGE
City or town CORAL HILLS
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5311- 2nd ST
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME LUCILLE FLYNN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	WHITE	MARRIED

6.(b) Name of husband or wife CHARLES L. FLYNN
6.(c) If alive, give age 49 years
7. Birth date of deceased (mo., day, yr.) DEC - 30 - 1906

8. AGE: Years	Months	Days	If less than one day
40			...hrs. ...min.

9. Birthplace CHARLESTON, S.C. (Town, county, and state)
10. Usual occupation HOUSE WIFE
11. Industry or business AT HOME
FATHER 12. Name LUDWICK HOPPMANN
13. Birthplace CHARLESTON. S.C.
MOTHER 14. Maiden name LEONA DICKENS
15. Birthplace SPARTA, GA.
16. Informant CHARLES L FLYNN
Address 5311- 2nd ST CORALS HILLS
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1. 47 (month) (day) (year)
Cemetery or crematory Arlington Cemetery
Location Arlington Va.
18. Funeral director H. D. Flanders CO
Address 517-11th ST. SE Wash. DC.
19. March 29 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947 at 5:20 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1947 to March 29 1947
and that I last saw h... alive on March 28 1947

Immediate cause of death	DURATION
Carcinoma of Colon.	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations Carcinoma of Colon
Date of op. 7th 1944
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William Brannin M. D. or other
Address Capitol Heights, Md. Date signed 3/29/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (143-M)

CERTIFICATE OF DEATH

03076

Reg. Dist. No. 2342

1. PLACE OF DEATH:
County: Prince George's
City or town: Camp Springs (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred: Near Jenkins Corner
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Suitland (If outside city or town limits, write RURAL and give nearest town)
Street No. 4717 Homer Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Edward Fowler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Evelyn Gertrude Fowler
6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): November 1911

8. AGE: Years	Months	Days	If less than one day
35			hrs. min.

9. Birthplace: Camp Springs, Md. (Town, county, and state)
10. Usual occupation: Cab Driver
11. Industry or business: Taxicab

FATHER
12. Name: Thomas F. Fowler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah E. Pyles
15. Birthplace: Maryland

18. Informant: James E. Fowler
Address: 1115 59th Ave., Hillside, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/7/47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.

18. Funeral director: Thomas F. Murray Funeral Home
Address: 2007 Nichols Ave S.E.

19. Mar. 6 19 47 Hugh J. Beach Registrar
(Date rec'd by registrar)
H. Beach Dir. 2 E. 20th

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 19 47 at 4:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Asphyxia	
Due to: Acute carbon monoxide poisoning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 3/5/47
Where did injury occur? Jenkins Corner (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?): In a woods
Means of injury: Piped exhaust into closed car. (Direct cause)

Deputy Medical Examiner
23. SIGNATURE: James D. Ford M.D. or other
Address: Forestville Md. Date signed 3-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-25

2 - 2340 — 1-10

Dr Jos. Boyd has been notified

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

03677

Reg. Dist. No. 2340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16

1. PLACE OF DEATH:

County: Pr. George

City or town: Clinton - Piscataway Road
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Pr George

City or town: Clinton - Piscataway Rd Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.:
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Elizabeth Gallahan

3. (b) Social Security Number:

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John Gallahan

6 (c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Dec 24 1875

8. AGE: Years: 71 Months: 2 Days: 14 If less than one day: hrs. min.

9. Birthplace: Clinton Pr Geo. Md
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Albert F. Jenkins
13. Birthplace: Pr Geo. Md

MOTHER — 14. Maiden name: Miss Margie Merrion
15. Birthplace: College Park Md

16. Informant: John Gallahan
Address: Clinton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 13, 1947 (month) (day) (year)

Cemetery or crematory: St Mary's

Location: Piscataway Md

18. Funeral director: Hewitt & Ryon

Address: Waldorf Md

19. 3/10 (Date rec'd by registrar) 1947 Mrs. Alton Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1947, at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1943, to March 10 1947, and that I last saw her alive on Feb 4 1947.

	DURATION
Immediate cause of death: Symmonds Disease	4 yr.
Due to: Pituitary Dysfunction	
Due to:	
Other conditions: Cachexia, Glycosuria	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C W Schwartz M.D.
M. D. or other

Address: 1225 Talbert St SE Date signed: Mar 10 1947

1 - 39

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03678

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1313 Stevenson Road, S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CHARLES GARTRELLE

3.(b) Social Security Number: 352-03-7913

4. Sex	5. Color or race	9.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife: Emma ?
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28, 1905

8. AGE: Years	Months	Days	If less than one day
41 41	9	19	hrs. min.

9. Birthplace: Washington, Georgia
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Rosslyn Steel Company

FATHER
12. Name: Lucia Gartreller
13. Birthplace: Washington, Georgia

MOTHER
14. Maiden name: Pearl Sutton
15. Birthplace: Washington, Georgia

16. Informant: Deceased
Address

17. removal (Burial, cremation, or removal. Which?) Date thereof Mar. 17, 1947 (month) (day) (year)
Cemetery or crematory: Washington D C
Location
19. Funeral director: Taft H. Williams
Address 1702 - 12 St, N.W., Washington, D.C.

19. Mar 17, 19 47 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 19 47 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 19 47, to Mar. 17 19 47
and that I last saw h. alive on Mar. 17 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 3/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2431 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-C)

CERTIFICATE OF DEATH

03079

Reg. Diat. No. 248

1. PLACE OF DEATH:

County Prince Georges

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Unknown

Hospital, institution, or street address where death occurred:

Marlboro Pike

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Pr. Geo. Co.

City or town Berwyn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9515 R.D. one

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Bernard Geisz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 25 1928

8. AGE: Years	Months	Days	If less than one day
18	7	19	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Garage attendant

11. Industry or business

FATHER — 12. Name Robert B. Geisz

13. Birthplace Baltimore, Md

MOTHER — 14. Maiden name Naomi Helder

15. Birthplace Md.

16. Informant Naomi Kephart, mother

Address 9514 R.D. One Berwyn, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 18 - 47 (month) (day) (year)

Cemetery or crematory Ft. Lincoln

Location Pr. Geo. Co. Md.

18. Funeral director D.W. Chamberlain Co.

Address Riverdale, Md.

19. March 17 1947 (Date rec'd by registrar) Mrs Lee Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947, at 12:00 P.M.

21. I CERTIFY that death occurred on the date above etated: that I attended deceaeed from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Fracture of skull, fracture of left femur	
Due to Compound fracture of left patella, fracture of left tibia and amputation	
Other conditions multiple abrasions of face, hands, legs, body	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of injury 3-14-47

Where did injury occur? Hyattsville (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Marlboro Pike

Manner of injury Motor cycle collision

Hospital Prince Georges medical Examiner

23. SIGNATURE ..... M. D. or other

Address Hyattsville Md. Date signed 3-15-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-2450 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-0)

CERTIFICATE OF DEATH

03080

Reg. Diat. No. 243

1. PLACE OF DEATH:

County Prince George's

City or town Woodmore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Woodmore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rose Fannie Gordon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Herman Gordon

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Jan 5 1888

8. AGE: Years 59 | Months 7 | Days 24 | If less than one day ... hrs. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual occupation Housemaker

11. Industry or business Own Home

FATHER 12. Name Kopel Berlin

FATHER 13. Birthplace Russia

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Russia

16. Informant Herman Gordon

Address Woodmore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 30, 1947 (month) (day) (year)

Cemetery or crematory Brai Israel Cemetery

Location Southern ave

18. Funeral director Sol Levinson & Bros.

Address 1124-26 N Howard ave

19. 3/29/ 1947 (Date rec'd by registrar) Louise H Peach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947, at 9:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 1947, to March 29 1947

and that I last saw h... alive on March 27 1947

Immediate cause of death	DURATION
Cerebral thrombosis	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James D. Ford M. D. or coroner

Address Frostburg Md Date signed 3-29-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03081

CERTIFICATE OF DEATH

Reg. Diat. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 2 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 810 - 5th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: GRAY, JAMES EDWARD

3.(b) Social Security Number: 230-05-6442

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: —

6.(c) If alive, give age: yeare

7. Birth date of deceased (mo., day, yr.): June 29, 1883

8. AGE: Yeare	Months	Days	If less than one day: hre.	min.
63 63	8	25		

9. Birthplace: Fredericksburg, Virginia
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER
12. Name: Oscar Gray
13. Birthplace: Fredericksburg, Virginia

MOTHER
14. Maiden name: Martha Ellen Shanault
15. Birthplace: Fredericksburg, Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/26/47 (month) (day) (year)

Cemetery or crematory: Washington Cemetery

Location: Suitland, Maryland.

18. Funeral director: W. W. Chambers Co.

Address: 1400 Chapin St. N.W. Wash. D.C.

19. Mar. 24 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 1947 at 155 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/21 1947, to 3/24 1947

and that I last saw him alive on 3/24 1947

Immediate cause of death	DURATION
pulm. tuberculosis	10 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: Mar. 24, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-25

2-2430-2-10

Evidence for the addition of items 4,5 is shown on G 109
3/31/47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

(942)

CERTIFICATE OF DEATH

03682

Reg. Dist. No. 2451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County PRINCE GEORGE
City or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred: Sacred Heart Home
5805 QUEEN CHAPEL RD
How long in hospital or institution? 2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State .... County
City or town Washington DC
(If outside city or town limits, write RURAL and give nearest town)
Street No. 25 Calvert St N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. HELEN GUIDER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	WID

6.(b) Name of husband or wife JAMES A GUIDER
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.) OCT. 27 1878

8. AGE: Years	Months	Days	If less than one day
69	4	21	.... hrs. .... min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name FLORENCE McAULIFFE
13. Birthplace Ireland.
MOTHER 14. Maiden name MARY CURTIN
15. Birthplace Ireland.
16. Informant RECORDS AT HOME.
Address Hyattsville Md.
17. transportation (Burial, cremation, or removal. Which?) Date thereof 3 - 7 - 1947 (month) (day) (year)
Cemetery or crematory
Location Syracuse N.Y.
18. Funeral director Jos Gawler's Sons
Address 1756 Penn Ave. N.W. D.C.
19. Mar. 7" 1947 Mrs. Jas. Severe Registrar
(Date rec'd by registrar) Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 6 1947, at 9 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to Mar 6 1947
and that I last saw h.er alive on Mar 6 1947

Immediate cause of death	DURATION
Coronary heart disease	3 months
Hypertensive basis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury .... Injured at work?

23. SIGNATURE Thomas Hallin MD
M. D. or other
Address 333 H ... NE Date signed 3-7-47

1-25

2-2450 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03083

Reg. Dist. No. 245

1. PLACE OF DEATH

County: Pro Geo Co.

City or town: Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Pro Geo Co

City or town: Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6320 Baltimore Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Grafton Harper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bertie Harper

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): June 6 1869

8. AGE: Years 77 Months . Days . If less than one day ... hrs. ... min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: crane operator

11. Industry or business: wests co.

FATHER

12. Name: Joseph Harper

13. Birthplace: Washington D.C.

MOTHER

14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Bertie Harper

Address: Riverdale Md

17. (Burial, cremation, or removal. Which?) Removal Date thereof: Mar 21, 1947 (month) (day) (year)

Cemetery or crematory: Lle Maine Funeral Home

Location: alexandria va

18. Funeral director: F Gaschie sons

Address: Hyattsville Md.

19. March 21st 19 47 (Date rec'd by registrar) Mrs. Jay Beavers Registrar Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 21, 19 47, at 1 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-20-47, 19..., to 3-21 19 47

and that I last saw h. 1 2... alive on 3-21-47 19...

	DURATION
Immediate cause of death: coronary occlusion	1 day
Due to: arteriosclerotic heart disease	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: John P. Clum M. D. or other

Address: Hyattsville Md Date signed 3-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

125

2-2450 —— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

63084

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince George's

City or town: Glenn Dale, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 2 mos., 4 days.

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 2 mos., 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 804 2nd St., S. E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME ADA HURSEY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Separated

6.(b) Name of husband or wife: Joseph Hursey

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): April 22, 1890

8. AGE: Years	Months	Days	If less than one day
56	10	12	...hrs. ...min.

8. Birthplace: Wilson, North Carolina (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: - -

FATHER — 12. Name: Thomas DuPree

13. Birthplace: Edgecomb, North Carolina

MOTHER — 14. Maiden name: Ida Bryons

15. Birthplace: Edgecomb, North Carolina

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar 5 1947 (month) (day) (year)

Cemetery or crematory

Location: to Wash. D.C.

18. Funeral director: Malvan & Schey Inc. (W.C.A)

Address: 424 R. St. N.W.

19. Mar 4 1947 Rowland S. Phillips

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 4 1947, at 5:45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29 1945, to March 4 1947

and that I last saw her alive on March 4 1947

Immediate cause of death: PULMONARY TUBERCULOSIS — DURATION: 2 yrs 3 m

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 3.4.47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2-2430 — 2-10

Residence: Film Geog 3/31/47

03085

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2421

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Prince George
City or town Suitland Road (If outside city or town limits, write RURAL and give nearest town) Washington 20 DC
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince George
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. 4212 Suitland Rd. Md. (If rural, give LOCATION) Washington 20 DC
2.(a) If veteran, name war

3.(a) FULL NAME Charles LLoyd. Jenkins
3.(b) Social Security Number none

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Dora L Jenkins
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) August 15th 1863
8. AGE: Years 83 Months Days If less than one day ... hrs. ... min.
9. Birthplace Washington D.C. (Town, county, and state)
10. Usual occupation Florist
11. Industry or business
FATHER 12. Name Richard L Jenkins
13. Birthplace Washington D.C.
MOTHER 14. Maiden name Henrietta Southorn
15. Birthplace Maryland
16. Informant Harry T Jenkins
Address 4298 Suitland Rd. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 17 1947 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland, Md.
18. Funeral director J. William Lee's Sons Co.
Address 300 - 4th St. N.E.
19. 3-15-47 (Date rec'd by registrar) Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947, at 2:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1947 to March 15 1947 and that I last saw him alive on March 14 1947

	DURATION
Immediate cause of death acute myocardial Decompensation	6 hrs
Due to Cardio vascular renal Disease	unknown
Due to —	
Other conditions none	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: none
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Paul C Van Natta M. D. or other
Address Washington 19 D.C. Date signed 3/15/47

VS A15 9-45-15M

1-25-

2-2420 —— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03086

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos., 8 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 6 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 128 F. St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MABELLE ALFREDA JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: --
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 25, 1928

8. AGE: Years	Months	Days	If less than one day
18	6	10	hrs. min.

9. Birthplace: Aiken, South Carolina (Town, county, and state)
10. Usual occupation: --
11. Industry or business: --

FATHER
12. Name: Fred Johnson
13. Birthplace: Columbus, Ohio

MOTHER
14. Maiden name: Not Known
15. Birthplace: Aiken, South Carolina

16. Informant: Deceased
Address

17. removal (Burial, cremation, or removal. Which?) Date thereof: March 5 1947 (month) (day) (year)
Cemetery or crematory
Location: to Wash. D.C.
18. Funeral director: W. Ernest Jaggers Co.
Address: 1432- You St. N.W. Wash D.C.

19. Mar 5 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 5 1947, at 7:25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG. 26 1946, to MARCH 5 1947
and that I last saw h... alive on MARCH 5 1947

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	11 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Md. Date signed: 3.5.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03087

CB

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 23 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1326 6th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: VALASKA JOHNSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Divorced

6.(b) Name of husband or wife: Edward Johnson

6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): March 16, 1918

8. AGE: Years	Months	Days	If less than one day
28	11	27	...hrs. ...min.

9. Birthplace: Rocky Mountain, North Carolina
(Town, county, and state)

10. Usual occupation: Government Clearner

11. Industry or business: Munitions Building

FATHER — 12. Name: Rev. N. D. M. Graham

FATHER — 13. Birthplace: Raleigh, North Carolina

MOTHER — 14. Maiden name: Sarah J. Bunn

MOTHER — 15. Birthplace: Unknown

16. Informant: Deceased

Address

17. removal (Burial, cremation, or removal. Which?) Date thereof: Mar 13, 1947 (month) (day) (year)

Cemetery or crematory

Location: to Wash. D.C.

18. Funeral director: Farmer Funeral Home Inc

Address: 389-R I ave NW

19. Mar 13, 19 47 Rowland S. Philips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 13 19 47 at 7 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DEC. 19 19 46 to MARCH 13 19 47

and that I last saw h...ER...alive on MARCH 13 19 47

	DURATION
Immediate cause of death: PULMONARY TUBERCULOSIS	5 mos
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 3.13.47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-25

2-2430 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

03088

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County 3703-43rd Ave. Pr. Geo.
City or town Cottage City, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pr. Geo. Co
City or town Cottage City, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3703-43rd Ave. Cottage City Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Arthur Minard Kendall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Myrtle Kendall
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) May 18 - 1888

8. AGE: Years	Months	Days	If less than one day
58			..... hrs. ..... min.

9. Birthplace Richmond, Va (Town, county, and state)
10. Usual occupation Salesman
11. Industry or business Service Paint & Paper Co.
FATHER 12. Name Joshua Kendall
13. Birthplace Va
MOTHER 14. Maiden name Annie King
15. Birthplace Va
18. Informant Myrtle Kendall
Address 3703-43rd Ave Cottage City Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 11-47 (month) (day) (year)
Cemetery or crematory Fort Lincoln Cem.
Location Md
18. Funeral director W W Chambers Co
Address Riverdale Md
19. 3/10 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8 1947, at 7 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1946, to 3-8 1947
and that I last saw h... alive on 3-8 1947

Immediate cause of death	DURATION
Coronary Occlusion	3 hrs
Due to Hypertension and Heart ✓ + Kidney disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Hugh Hagan M. D. or other
Address 3717-37th Ave Date signed 3/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

Evidence for the change of age is shown on G109 4/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-b)

CERTIFICATE OF DEATH

03089

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince George
City or town: Cottage City, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, institution, or street address where death occurred:
3704 - 41st Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George
City or town: Cottage City Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3704 - 41 Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: George Charles Kern

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 23 1889

8. AGE: Years	Months	Days	If less than one day
57	1	58	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business:
FATHER 12. Name: Henry P Kern
13. Birthplace: Germany
MOTHER 14. Maiden name: Carolina R. Koons
15. Birthplace: Md.
16. Informant: John P Kern
Address: Clinton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-24-47 (month) (day) (year)
Cemetery or crematory: Arbor Hill Cemetery
Location: Pr. George Co.
18. Funeral director: J. William Lee's Sons
Address: 300 - 4th N.E.
19. 3/24 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21, 1947, at 7:10 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 14, 1947, to March 21, 1947
and that I last saw him alive on March 21, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 year +
Due to:	
Due to:	
Other conditions: Myocarditis	24 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. Stratton Hurlburt M. D. or other
Address: 3000 Dent Place, NW Date signed: Mar. 22, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16 P-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B 03090

Reg. Diat. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 5 mos., 10 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 4 yrs., 5 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 802 - 49th St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: HERMAN KIMBROUGH

3. (b) Social Security Number: 238-18-7077

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Luvina Kimbrough

6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1918

8. AGE: Years	Months	Days	If less than one day
29	0	5	....hrs. ....min.

9. Birthplace: Brodford, Alabama
(Town, county, and state)

10. Usual occupation: Photostating

11. Industry or business:

FATHER
12. Name: Robert Kimbrough
13. Birthplace: Alabama

MOTHER
14. Maiden name: Tempie Donzy
15. Birthplace: Alabama

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3 . 4 . 47 (month) (day) (year)

Cemetery or crematory: To Wash. Dc.

Location:

18. Funeral director: Henry S. Washington & Sons

Address: 467 N St. N.W.

19. Mar 3 19 47 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 19 47 at 635 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/22/ 19 42 to 3/3/ 19 47

and that I last saw h.. alive on 3/3/ 19 47

Immediate cause of death	DURATION
Pulmonary tuberculosis	4 yr
Due to	7 mo
	3 da
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 3/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-24 30 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-2)

CERTIFICATE OF DEATH

★ 03091

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 1/2 hrs.
Hospital, institution, or street address where death occurred:
Prince Geo. Hosp., 14 1/2 hrs.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Decatur Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5206 Tildon Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lamb, male infant

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	—

6.(b) Name of husband or wife: —
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 27. 1947

8. AGE: Years | Months | Days | If less than one day: 14 hrs. 30 min.

9. Birthplace: Cheverly, Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER
12. Name: Franklin Lamb
13. Birthplace: Arizona

MOTHER
14. Maiden name: Florence Casey
15. Birthplace: N.Y.

16. Informant: Franklin Lamb
Address: Decatur Heights Md.

17. Burial.
(Burial, cremation, or removal. Which?) Date thereof: May 31. 1947. (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Washington D.C.

18. Funeral director: F. Gasch & Sons
Address: Hyattsville Md.

19. 3/31 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-28 1947 at 7 05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 00 p.m. 3/27 1947 to 3/28 1947
and that I last saw h. liv. alive on 3 30 a.m. 3/28 1947

Immediate cause of death	DURATION
Bilateral Hemorrhage of Kidneys	
Due to: Cause unknown	
Due to:	
Other conditions: Patent Ductus Arteriosus	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: Same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John W. Maloney M D
M. D. or other
Address: Cheverly Md. Date signed: 3-28-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03092

CB Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Days
Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital
How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dis. of Columbia County: –
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3041 Bladensburg Road, N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: – /

3.(a) FULL NAME: Phillip Taylor Layman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Singel

6.(b) Name of husband or wife: –
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): January 18, 1947

8. AGE: Years	Months	Days	If less than one day
	1	20	____ hrs. ____ min.

9. Birthplace: Cheverly, Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: Roland Marion Layman
13. Birthplace: Hagerstown, Maryland
MOTHER 14. Maiden name: Betty Maxine Watson
15. Birthplace: Portland, Oregon
16. Informant: Hospital Records
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/17/47 (month) (day) (year)
Cemetery or crematory:
Location: Lewistown, Md.
18. Funeral director: W. W. Chambers Co
Address: Riverdale - md
19. March 11 1947 (Date rec'd by registrar) James E. Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10, 1947, at 12:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1947, to Mar 10 1947 and that I last saw him alive on Mar 10 1947

Immediate cause of death	DURATION
Pneumococcic ? Meningitis	10 days.
Due to:	
Due to:	
Other conditions Peritonitis	2 days.

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: L W Malin M D M. D. or other
4414 Bladensburg Road
Address: Riverdale, Maryland Date signed ____

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03093

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 17 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? one month, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2122 Decatur Pl., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LEE EDITH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Bernard Lee

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 29, 1878

8. AGE: Years	Months	Days	If less than one day
68	9	24	hrs. min.

9. Birthplace: Perryville, Indiana
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Ben F. Kemp
13. Birthplace: ? Indiana

MOTHER
14. Maiden name: Alice Morrison
15. Birthplace: ? Indiana

16. Informant: Daughter, Frances Aker
Address: 2122 Decatur Pl, N. W.

17. Removal to
(Burial, cremation, or removal. Which?)
Date thereof: Mar. 23, 1947
(month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Gilbert C. Vincent

Address: 254 Carroll St N.W.

19. Mar. 23 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/23 1947 at 3^10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/5 1947 to 3/23 1947

and that I last saw h.. alive on 3/23 1947

Immediate cause of death	DURATION
(a) Pulmonary Tuberculosis	7 mos.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lea Pinncane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: Mar. 23, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2 - 25

2 - 2430 —— 2 - 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-A)

CERTIFICATE OF DEATH

03094

Reg. Diat. No. 450

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hrs

Hospital, institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hyattsville Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 212 - Avenue E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Karl Leivo

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Helma Leivo

6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1894

8. AGE: Years 53 | Months 1 | Days 10 | If less than one day ____ hrs. ____ min.

9. Birthplace Finland (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Construction

FATHER 12. Name Gustava Leivo

FATHER 13. Birthplace Finland

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace Finland

16. Informant Carl Rejo Leivo

Address 4662 Homer Ave, Suitland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 25, 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland Md.

18. Funeral director F. Gasch & sons

Address Hyattsville Md.

19. Mar 25 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 21 1947, at 9 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____

and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Coronary occlusion	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Deputy medical examiner James H Boyd M.D. or other

Address Forestville md Date signed 3-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of year of birth shown on film D109-3/19/47-B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

03095

B

Reg. Dist. No. 2450

1. PLACE OF DEATH:
County: Prince George's
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hrs
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Minnesota County: Carlton
City or town: Cloquet
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D. # 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Walter E. Lennartson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male M	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 20, ~~1947~~ 1924

8. AGE: Years: 22 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Mahtowa, Minn. (Town, county, and state)

10. Usual occupation: Student

11. Industry or business: University of Maryland

FATHER
12. Name: Lloyd W. Lennartson
13. Birthplace: Minn.

MOTHER
14. Maiden name: Ellen Carlson
15. Birthplace: Minn

16. Informant: Roy W. Lennartson
Address: 1446 Tuckerman Street N. W., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 10-47 (month) (day) (year)
Cemetery or crematory: Duluth
Location: Minn.
18. Funeral director: W W Chambers Co.
Address: Riverdale, Md.

19. March 10 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 19 47 at 3:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Cerebral compression	
Due to: Intra cranial hemorrhage	
Due to: Fracture of the skull	
Other conditions: Compound comminuted fracture of the left leg. Crushed pelvis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 3/8/47
Where did injury occur? Hyattsville (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Route # 1
Means of injury: Pedestrian struck by an auto (injured at work?)

23. SIGNATURE: James F. Boyd M. D. or other
Deputy Medical Examiner
Address: Forestville, Md. Date signed: 3/9/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C B 03096

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos., 28 days.

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 4 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 310 - 16th St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MILDRED LONG

3.(b) Social Security Number: 579-07-4850

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 8, 1920

8. AGE: Years	Months	Days	If less than one day
26	11	1	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Cashier

11. Industry or business: - -

FATHER
12. Name: Jameson Long
13. Birthplace: Vienna, Virginia

MOTHER
14. Maiden name: Anna Green
15. Birthplace: Philadelphia, Pennsylvania

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 3/10/47 (month) (day) (year)

Cemetery or crematory:

Location: Fairfax - Fairfax Va.

18. Funeral director: J. S. Grubb

Address: Alexandria, Virginia

19. Mar. 9, 1947 (Date rec'd by registrar) Rowland B. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9th 1947, at 12 05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10th 1945 to March 9th 1947

and that I last saw h.. alive on March 9th 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 yrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 3/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430 — 2-10

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13Fa)

CERTIFICATE OF DEATH

★ 13097

Reg. Diat. No. 2475

1. PLACE OF DEATH:

County: Prince Geo.

City or town: Brentwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Geo.

City or town: Brentwood
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3707 - Tilden St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Fred O. McLelland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marguerite M. McLelland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 16, 1886

8. AGE: Years: 60 | Months: 11 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Huron, Dakota, Beadel County
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Charles Douglas McLelland
13. Birthplace: Ravenna, Ohio

MOTHER
14. Maiden name: Emma E. Terry
15. Birthplace: Ravenna, Ohio

16. Informant: Mrs. Emma Smith
Address: 709 - A - Street N.E. Wash. D.C.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: March 20 1947
(month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Lincoln Rd. Wash. D.C.

19. Funeral director: Wm. J. Nalley

Address: 3200 - R. I. Ave. Mt. Rainier Md.

19. March 19 1947 James Seay
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 17 1947 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3 1947 to March 17 1947
and that I last saw h... alive on February 28 1947

	DURATION
Immediate cause of death: Cardiovascular renal disease	several months
Due to: Generalized Arteriosclerosis	several months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other

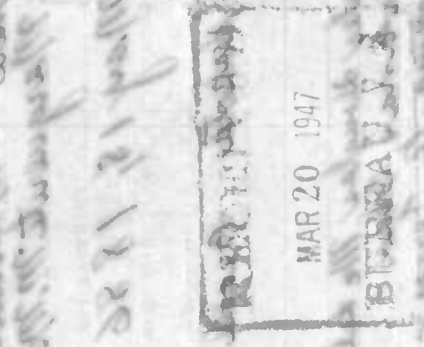
Address: Mt. Rainier Md. Date signed: 3-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Coroner notified and will approve.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21a)

CERTIFICATE OF DEATH

03098

Reg. Dist. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 month
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Laurel Maryland (Rural) (If outside city or town limits, write RURAL and give nearest town)
Street No.: Montgomery Road (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clyde Raymond Marton, Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Katurah Brown Marton
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 18, 1876

8. AGE:

Years	Months	Days	If less than one day
70	10	3	hrs. min.

9. Birthplace: Laurel, Maryland (Town, county, and state)
10. Usual occupation: Retired machinist
11. Industry or business: U. S. Navy Yard
FATHER 12. Name: David Stillard Marton
13. Birthplace: Pennsylvania
MOTHER 14. Maiden name: Martha Sewell
15. Birthplace: Laurel, Maryland
18. Informant: Clyde R. Marton, Jr.
Address: Laurel, Maryland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 24 1947 (month) (day) (year)
Cemetery or crematory: Ivy Hill Cemetery
Location: Laurel, Maryland
18. Funeral director: De Hitt Donaldson
Address: Laurel, Maryland.
19. Mar 23 1947 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 20 1947, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 10 1947, to 3 20 1947 and that I last saw h living alive on 3 20 1947

Immediate cause of death	DURATION
Coronary occlusion	10 m.
Due to: Hypertension	
Due to: Gen. Arteriosclerosis	5 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B P Warren M. D. or other
Address: Laurel Md. Date signed: 3-23-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-a)

CERTIFICATE OF DEATH

03099

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince George

City or town: Capitol Hgts.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred: 418 - 30th ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Capitol Hgts
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 418-30th Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: FRANK NAVARRIA - (NAURRIA)

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Maria Navarria

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan 16 1873

8. AGE: Years: 72 | Months: 2 | Days: 14 | If less than one day: ... hrs. ... min.

9. Birthplace: Sicily
(Town, county, and state)

10. Usual occupation: Shoemaker

11. Industry or business:

FATHER
12. Name: Domonic Navarria
13. Birthplace: Sicily

MOTHER
14. Maiden name: Ana Bruno
15. Birthplace: Sicily

16. Informant: Mary Falsonetti
Address: 418 - 30th Ave. Capt Hgts

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: apl 2 47
(month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Maryland

18. Funeral director: L.L. Chambers Co

Address: 917 - 11 St NE

19. 3/31/47 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1947 at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: Congestive heart failure — DURATION

Due to: Chronic Coronary insufficiency

Due to: Cardiovascular renal disease

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner James J. Lord M. D. or other

Address: Forestville Md Date signed: 3-30-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1643)

03100

CERTIFICATE OF DEATH

Reg. Dist. No. 8c

1. PLACE OF DEATH:
County Prince George's
City or town Mitchellville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Permanent
Hospital, Institution, or street address where death occurred:
In woods near Crane Highway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1501 - North Paterson Park Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war World War #1

3.(a) FULL NAME Amos Neuman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 12, 1900

8. AGE: Years 46 | Months | Days | If less than one day hrs. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual occupation Storekeeper

11. Industry or business Confectionery

FATHER
12. Name Anton Neuman
13. Birthplace Czechoslovakia

MOTHER
14. Maiden name Josephine Vogan
15. Birthplace Poland

16. Informant Jerome Ulrich
Address 4205 - Sheldon Ave Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/21/1947 (month) (day) (year)
Cemetery or crematory xxx Oak Hill
Location Horner's Lane, Baltimore, Md.

18. Funeral director Charles E. Schimunek
Address 2601-03 E. Madison Street

19. March 19, 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1947, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Gun-Shot Wound of Head	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Suicide Date of 3-17-47
Where did injury occur? Mitchellville (City or town) Prince George's (County) Md. (State)
Injured at home, farm, industry, public place (where?) In Woods
Means of injury Shot in head with pistol Injured at work?

Deputy medical examiner

23. SIGNATURE ... M. D. or other
Address Forestville, Md. Date signed 3-17-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

03101

Reg. Dist. No. 2390

1. PLACE OF DEATH:
County: Prince Georges
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Yrs. 5 M. 24 D
Hospital, institution, or street address where death occurred:
Laurel Sanitarium
How long in hospital or institution? 6 Yrs. 5 M. 24 D

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)
Street No. 8419 Piney Branch Road (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anton Nimmerichter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Anna Barilitsch
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 5 - 1879

8. AGE: Years	Months	Days	If less than one day
68	0	12	____ hrs. ____ min.

9. Birthplace: Vienna, Austria (Town, county, and state)
10. Usual occupation: Butcher
11. Industry or business:
FATHER — 12. Name: Anton Nimmerichter
FATHER — 13. Birthplace: Vienna Austria
MOTHER — 14. Maiden name: Antonia Zebesh
MOTHER — 15. Birthplace: Vienna, Austria
16. Informant: Sanitarium Records
Address: Laurel San; Laurel, Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 17, 1947 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: James R Ryan Inc.
Address: 317 Penna. Ave. S.E.
19. Mar 17 1947 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1947, at 12:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 24 1946, to March 17 1947, and that I last saw him alive on March 17 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	3/16/47
Due to: General Arteriosclerosis	Unk
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: John L. Methered, M.D. M. D. or other
Address: Laurel Sanitarium, Laurel, Md
Date signed: 3/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

03192

Reg. Diat. No. 2400

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheltenham Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Cheltenham

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ellie Isabella Oliver

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widowed

6.(b) Name of husband or wife: James Frank Oliver

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 12 - 1869.

8. AGE:

Years	Months	Days	If less than one day
77	11	19	hrs. min.

9. Birthplace: Largo P. Geo. Co., Md.

(Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER — 12. Name: Julius A. Pyles

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: Harriet Stansbury

MOTHER — 15. Birthplace: unknown

16. Informant: Jesse R. Oliver

Address: Cheltenham, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-6-47. (month) (day) (year)

Cemetery or crematory: Cheltenham Methodist

Location: Cheltenham, Md.

18. Funeral director: Pitcher Brothers

Address: Upper Marlboro, Md.

19. March 2 1947 F. H. Billingsley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 1947, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1940, to March 1st 1947 and that I last saw h[illegible] alive on Nov 15 1947

	DURATION
Immediate cause of death: Leomyosarcoma Thrombosis	6 hours
Due to: Diabetes	6 years
Due to:	
Other conditions: Arteriosclerosis	Several years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John E. Powers M. D., or other

Address: Brandywine, Md. Date signed: 3/6/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on Film G 109 - 3/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

★ 03103

Reg. Dist. No. 7451

1. PLACE OF DEATH:
County: Pr Geo Co
City or town: Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr Geo Co
City or town: Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4508 Rittenhouse St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Roland Earl Oursler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Carolyn B. Oursler
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Nov 25, 1886

8. AGE: Years	Months	Days	If less than one day
60 6t			hrs. min.

9. Birthplace: Baltimore Md
(Town, county, and state)
10. Usual occupation: Contractor
11. Industry or business: own business
FATHER 12. Name: Azariat Oursler
13. Birthplace: Md
MOTHER 14. Maiden name: Jane Gladeon
15. Birthplace: Md
16. Informant: Carolyn B. Oursler
Address: Riverdale Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 18, 1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington D.C. Columbia Mausoleum Md.
19. Funeral director: F Galeto Long
Address: Hyattsville Md.
19. March 15 1947 (Date rec'd by registrar) Mona Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13. 1947, at 5.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 1946, to March 13 1947
and that I last saw h alive on March 13 1947

Immediate cause of death	DURATION
Myocardial Insufficiency	
due to Myocardial	
Due to Degeneration	
Due to	
Other conditions Acute Uremia of Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hyattsville Md Date signed 3-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-2450 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03104

CERTIFICATE OF DEATH

Reg. Diat. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3409 Prospect Avenue, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Arthur Lee Overholtz

3. (b) Social Security Number: 230-09-4610

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: yeare

7. Birth date of deceased (mo., day, yr.): November 25, 1888

8. AGE: Years	Months	Days	If less than one day
58 58	4	1	hrs. min.

9. Birthplace: Mount Jackson Va.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: Gestaven University

FATHER
12. Name: Anderson Overholtz
13. Birthplace: Mount Jackson Va.

MOTHER
14. Maiden name: Katherine McDonald
15. Birthplace: Mount Jackson Va.

16. Informant: Mrs Maud Hines
Address: 311 C St S.E. Wash DC

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Mar. 26. 1947 (month) (day) (year)
Cemetery or crematory: Prospect Hill
Location: Front Royal Va.

18. Funeral director: A. B. Scott
Address: Front Royal Va.

19. Mar. 26, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1947, at 9:55 A M

21. I CERTIFY that death occurred on the date above etated: that I attended deceased from March 25 1947 to Mar 26 1947

aed that I last saw h... alive on Mar. 26 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 2 mos

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: Mar. 26, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2-2430-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03106

Reg. Diat. No. 2437

1. PLACE OF DEATH: County: Prince Georges — City or town: Mitchellville (If outside city or town limits, write RURAL and give nearest town) — How long in above place of death? — Hospital, Institution, or street address where death occurred: — How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State: Md. County: Prince Georges — City or town: Mitchellville (If outside city or town limits, write RURAL and give nearest town) — Street No. — (If rural, give LOCATION) — 2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Carnel Owens — 3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	single

6.(b) Name of husband or wife: — 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Nov. 6 1946

8. AGE: Years: — Months: 4 — Days: 4 — If less than one day: ... hrs. ... min.

9. Birthplace: Johns Hopkins Hospital (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: John T. Owens — 13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Henretta Turner — 15. Birthplace: Queen Ann

16. Informant: Henretta Owens — Address: Mitchellville, Md.

17. Burial (Burial, cremation, or removal. Which?) — Date thereof: Mar. 12 1947 (month) (day) (year)

Cemetery or crematory: Bowie,

Location: Harwood

18. Funeral director: J. B. Johnson

Address: Jamesapolis

19. March 12, 19 47 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1947, at 8 25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-1 1947, to 2-3- 1947 and that I last saw h[illegible] alive on 2-3-47 1947

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: A. T. Talley M.D. — M. D. or other

Address: 17 Concord St — Date signed: 3-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-2480 ——— 1-10

Evidence for the addition of place of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

03105

CERTIFICATE OF DEATH

Reg. No. G 109 APR 17 1947

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County 5302 Annapolis Rd. Md Pr. Geo.
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
5308 Annapolis, Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George Co.
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5302 Annapolis Rd. Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Thomas A Patterson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Elizabeth A. Patterson
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 11th 1894

8. AGE: Years	Months	Days	If less than one day
53	1	19	hrs. min.

9. Birthplace Renkio Asia Minor Turkey
(Town, county, and state)
10. Usual occupation Wholesale Coffee Dealer
11. Industry or business
FATHER 12. Name Angelos Patterson
13. Birthplace Asia Minor Turkey
MOTHER 14. Maiden name
15. Birthplace Asia Minor Turkey
16. Informant Mr. Constantine A. Patterson
Address 5411 North Capital St.
17. Removal Date thereof March 30 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fort Lincoln Cem.
Location Suitland, Md.
18. Funeral director The S. H. Hines Co
Address 2401-14 st n.w.
19. 3/30 19 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th, 1947 at 9:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 17 44 to March 30th 1947
and that I last saw him alive on 3/30/47
Immediate cause of death Cerebral Hemorrhage (Heprtention ---------- 3 years)
Due to Acute Hypertention
Due to
Other conditions None
(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury none Injured at work?

23. SIGNATURE Chas J. Demas MD
M. D. or other
Address 1301 Mass. Ave. N. W. Date signed 3/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

CR 03107

Reg. Dist. No. 2458

Eugene Leland Memorial Hospital.

1. PLACE OF DEATH:

County Prince George

City or town Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:
Leland memorial hospital

How long in hospital or institution? 2-28-47 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4708 Nichols Ave S.W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr. Robert Lincoln Porter.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Divorced.

6.(b) Name of husband or wife Caroline Acrey.

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) May 29, 1892.

8. AGE: Years	Months	Days	If less than one day
54	10	16	hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Marine Engineer.

11. Industry or business

FATHER 12. Name Frank Porter.

FATHER 13. Birthplace South Carolina.

MOTHER 14. Maiden name Eliz. Dunn Reed.

MOTHER 15. Birthplace South Carolina.

16. Informant Leland Memorial Hospital Records

Address Riverdale, Md

17. (Burial, cremation, or removal. Which?) Cremation Date thereof May 18 1947
(month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Bladensburg, D.C.

18. Funeral director Chevy Chase Funeral Home Ernest Adams

Address 5103 Wis ave nw Washington D.C.

19. March 16 1947 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Feb 28 1947, to March 16 1947, and that I last saw him alive on Mar 16 1947.

	DURATION
Immediate cause of death (Congestive) Heart Failure	6 week
Due to Coronary Thrombosis	2 years
Due to Arteriosclerotic Heart Dis.	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L W Malin M D
M. D. or other

Address Riverdale Md Date signed 3/16/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C3108

Reg. Dist. No. 2390

1. PLACE OF DEATH:
County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George L. Preston

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Unknown

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9 1879

8. AGE: Years	Months	Days	If less than one day
67	3	9	hrs. min.

9. Birthplace Winchester Va
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
12. Name of Father James Preston
13. Birthplace Virginia
14. Maiden name of Mother Unknown
15. Birthplace "
16. Informant George Matthews
Address 9th St Laurel Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 20 1947 (month) (day) (year)
Cemetery or crematory Munkirk
Location Munkirk Md
18. Funeral director Ridgely Sellers
Address 401 Washington Laurel Md
19. Mar 20 1947 M. Brashears Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1947 at 1:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5 1936 to Mar 17 1947
and that I last saw him alive on Mar 18 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hour
Due to Hypertension	15 yrs
Myocarditis	"
Due to Syphilis	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. M. Warren M.D. M. D. or other
Address Laurel Md Date signed 3-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03109

Reg. Dist. No. 2431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 10 days.
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 months, 10 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 634 N. St., N. W., Apt. #5 B
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: NOBLE MADISON PRICE

3.(b) Social Security Number: 225-10-5007

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Edna Price
6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): May 9, 1909

8. AGE:	Years	Months	Days	If less than one day
	37	9	27	hrs. min.

9. Birthplace: Alexandria, Virginia (Town, county, and state)
10. Usual occupation: Delivery Boy
11. Industry or business: Arcade Market
FATHER 12. Name: Walter Price
FATHER 13. Birthplace: South Carolina
MOTHER 14. Maiden name: Elizabeth Johnson
MOTHER 15. Birthplace: Virginia
16. Informant: Deceased
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar. 8, 1947 (month) (day) (year)
Cemetery or crematory:
Location: To Washington D.C.;
18. Funeral director: John T. Rhiner.
Address: 901-3 rd S.W.
19. 3/6/47 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1947, at 11:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/25/1946, to 3/6/1947 and that I last saw h... alive on 3/6/1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 3/6/47

2-25

2-2450 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

03110

Reg. Diat. No. 2300

1. PLACE OF DEATH

County: Prince George

City or town: Bladensburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Bladensburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Maude Roby

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Marcellus Roby

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 3 1872

8. AGE:

Years	Months	Days	If less than one day
74	5	14	hrs. min.

9. Birthplace: Bladensburg Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER

12. Name: George Parker

13. Birthplace: Washington D.C.

MOTHER

14. Maiden name: Amanda Mae Masterson

15. Birthplace: Washington D.C.

16. Informant: Mrs. Maude Roby

Address: Bladensburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19 1947 (month) (day) (year)

Cemetery or crematory: St Johns

Location: Bladensburg Md

18. Funeral director: W. H. Donaldson

Address: Laurel Md

19. March 18 1947 (Date rec'd by registrar) John L. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-17 1947, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 1938 to 19.....

and that I last saw her alive on 3-16-47 19.....

Immediate cause of death	DURATION
Bronchopneumonia	3 Days
Due to Metastatic Carcinoma	
of Brain	
Due to Carcinoma of Breast	2 Mos.
and Lymph Glands	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. M. Warren M.D. M. D. or other

Address: Laurel Date signed: 3/18/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1 ~ 55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-P)

03111

CERTIFICATE OF DEATH

Reg. Dist. No. 1451

1. PLACE OF DEATH
County: Pr. Geo. Co.
City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Pr. Geo Co.
City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)
Street No.: 6083-43rd ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frances Stewart Root

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Syrus Root
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 6-1867

8. AGE: Years: 79 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Isaac Stewart
13. Birthplace: Md.

MOTHER
14. Maiden name: Margaret Kelcher
15. Birthplace: Wash D.C.

16. Informant: Mildred C. Derby
Address: 6003-43rd ave Hyattsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-31-47 (month) (day) (year)
Cemetery or crematory: Congressional Cemetery
Location: Wash D.C.
18. Funeral director: W W Chamberlain Co
Address: Riverdale Md

19. March 31 1947 (Date rec'd by registrar) Mrs. Jas. Sevens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1947 at 8AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 1947 to March 29 1947
and that I last saw h.e alive on March 29/47 1947

	DURATION
Immediate cause of death: Trauma	
Due to: Cerebral thrombosis	
Due to: Arteriosclerosis	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John H Bayly M. D. or other
Address: 1726 Eye N.W. Washington D.C. Date signed: March 29, 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

2-25

2-2450 — 2-CO

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

03112 7475

Reg. Diat. No.

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 3/4 hrs

Hospital, Institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Beltsville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma Roy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Willie Roy

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1899

8. AGE: Years	Months	Days	If less than one day
48			hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: Riley Military Academy

FATHER 12. Name: Albert Braxton

FATHER 13. Birthplace: Richmond County, Va

MOTHER 14. Maiden name: Octavia Thompson

MOTHER 15. Birthplace: Virginia

16. Informant: Cleveland Braxton

Address: Munich Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-5-47 (month) (day) (year)

Cemetery or crematory: Washington Funeral Home

Location: Washington D.C.

18. Funeral director: F. Gaschis Sons

Address: Hyattsville, Md.

19. March 5 1947 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 1947, at 12 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Impingement and shock	
Due to: Compound Comminuted fracture of both legs, fracture of	
Due to: left jaw and Cerebral concussion	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 3-4-47

Where did injury occur? Prince Georges (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route #1

Means of injury: Pedestrian struck by Injured at work?

Deputy medical Examiner

23. SIGNATURE: [illegible] M. D. or other

Address: Hyattsville Md Date signed 3-4-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important! Physicians: please write the causes of death clearly and legibly.

1-25

2-2450 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03113

Reg. Dist. No. 2431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1311 Corcoran St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HENRY RUSSELL

3.(b) Social Security Number: 577-22-4567

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	single

6.(b) Name of husband or wife: - -

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 6, 1905

8. AGE: Years	Months	Days	If less than one day
41	11	0	..... hrs. ..... min.

9. Birthplace: Durham, North Carolina
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business: - -

FATHER
12. Name: I. H. Russell
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mattie Seaton
15. Birthplace: Unknown

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar. 6, 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: Frazier's Funeral Home Inc.

Address: 389-R.I. Ave. N.W. Wash. D.C.

19. Mar. 6, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6th 1947, at 3 05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from: Feby 24th 1947, to March 6th 1947

and that I last saw him alive on March 6th 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 3/6/47

2-25

2-2430 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH

03114

Reg. Dist. No. 250

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred: 4508 Tuckerman Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4508 Tuckerman Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY A. SCHAEFER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George M. Schaefer
6.(c) If alive, give age: --

7. Birth date of deceased (mo., day, yr.): November 5, 1866

8. AGE: Years	Months	Days	If less than one day
80	4	0	...hrs. ...min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: --

FATHER
12. Name: William Krendes
13. Birthplace: Germany

MOTHER
14. Maiden name: Sophie Potzler
15. Birthplace: Germany

16. Informant: Mrs. Bertha E. Kirby
Address: 4508 Tuckerman Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 8, 1947 (month) (day) (year)
Cemetery or crematory: Mount Olivet Cemetery
Location: Washington, D.C.
18. Funeral director: James T. Ryan, Inc.
Address: 317 Penna. Ave., S.E.
19. 3/6 1947 (Date rec'd by registrar) Amanda Dawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1947 at 4:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-15 1947, to 3-5 1947
and that I last saw her alive on 3-4 1947

Immediate cause of death	DURATION
Cardiac Hemiplegia	1 week
Arteriolar Fibrillation	3 weeks
Due to: Hypertension Cardiac	
Vascular Disease	5 years?
Due to:	
Other conditions: Severe Cold	3 weeks
Senility	5 years?

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. A. Bellinger 2nd M. D. M. D. or other
Address: Mt. Rainier Md. Date signed: 3-5-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

03115

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos., 5 days.
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 4 mos., 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infante give residence of mother)
State: D. C. County:
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 4425 Minnesota Ave., N. E. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: EDWARD SCOTT

3.(b) Social Security Number: 577-24-5401

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: - -
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 16, 1922

8. AGE: Years	Months	Days	If less than one day
25	1	3	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business: - -

FATHER
12. Name: Ernest L. Scott
13. Birthplace: Culpeper, Virginia

MOTHER
14. Maiden name: Francis Johnson
15. Birthplace: Washington, D. C.

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar. 19, 1947 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.
18. Funeral director: W. Ernest Jarvis Co.
Address: 1432-U St. N.W. Wash. D.C.
19. Mar. 19, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19th 1947 at 10:20 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 13th 1946 to March 19 1947
and that I last saw him alive on March 19th 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs. 2 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: David Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: Mar 19, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

03116

Reg. Dist. No. 245 1

1. PLACE OF DEATH:

County: Prince George's

City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: P. G.

City or town: Mt. Rainier (If outside city or town limits, write RURAL and give nearest town)

Street No. 4028 - 35th St. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Mr. Frank Joseph Sloan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Martha J. Sloan

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): June 2, 1877

8. AGE:

Years	Months	Days	If less than one day
69	9	17	...hrs. ...min.

9. Birthplace: Harpers Ferry, W. Va. (Town, county, and state)

10. Usual occupation: Printer

11. Industry or business:

FATHER

12. Name: Lockland Sloan

13. Birthplace: ? W. Va.

MOTHER

14. Maiden name: Nancy Ellen Kelly

15. Birthplace: ? W. Va.

16. Informant: Leland Memorial Hospital Records

Address: Riverdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 19 1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Washington D. C. Dist Sec

18. Funeral director: J. William Lee's Sons Co.

Address: 300 - 4th St N.E. Wash. D.C.

19. March 19th 1947 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1947 at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to Mar 19 1947 and that I last saw him alive on Mar 18 1947

Immediate cause of death	DURATION
Coronary arteriosclerotic Heart Disease with	1 week
Due to: Myocardial Infarction and Congestive Heart	
Due to: failure.	
Other conditions: Bronchial Asthma.	30 Years.

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Samuel J. N. Sugar M.D. M. D. or other

Address: 4300 Raywood Drive Mt Rainier, Md. Date signed: 19 Mar 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-2450 —1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03117

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution? 18

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. George
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3303 - Bunker Hill Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Benjamin F. Smith
3. (b) Social Security Number:

4. Sex: M.
5. Color or race: W
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife: Mrs. Rosa Ellen Smith
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct. 3 - 1876
8. AGE: Years: 70 Months: Days: If less than one day: hrs. min.
9. Birthplace: N. C. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER 12. Name: Orren - Smith
13. Birthplace: N. C.
MOTHER 14. Maiden name: Louisa Brougston
15. Birthplace:
16. Informant: Wife
Address: Same.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Bladensburg Rd. & D.C. Line
18. Funeral director: Wm. J. Malley
Address: 3200 - R.I. Ave. Mt. Rainier, Md.
18. 3/6 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 4, 1947, at 4:35 A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 14, 1947, to MARCH 4, 1947
and that I last saw h...m alive on March 3, 1947.

	DURATION
Immediate cause of death: CARDIOVASCULAR Renal Disease	1 yr
Due to: Generalized Arteriosclerosis	1 yr.
Due to:	
Other conditions: Arteriosclerotic H.T. Disease	Few Months

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: ISIDOR M. LAVINE M. D. or other
Address: Mt. RAINIER, MD. Date signed 3/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03113 36

1. PLACE OF DEATH:

County Prince George

City or town Chapel Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, institution, or street address where death occurred:

8940 Old Fort Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Chapel Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8940 Old Fort Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Columbus Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife Consuelo Smith

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1887

8. AGE: Years 59 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER — 12. Name James A. Smith

FATHER — 13. Birthplace Maryland

MOTHER — 14. Maiden name Mary E. Bolden

MOTHER — 15. Birthplace Maryland

16. Informant Consuelo Smith

Address 8940 Old Fort Road

17. Burial (Burial, cremation, or removal, which?) Date thereof Mar. 28 1947 (month) (day) (year)

Cemetery or crematory Chapel Hill

Location Chapel Hill Md.

18. Funeral director Robert G. Mason

Address 2500 Nichols Av. S E D.C.

19. 3/24 19 47 (Date rec'd by registrar) Mrs Alton Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 47, at 1.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy medical Examiner

23. SIGNATURE ... M. D. or other

Address Hyattsville Md Date signed 3-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03119

Reg. Dist. No. 2451

1. PLACE OF DEATH:
County: Pr Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pr Geo Co
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4524 Buchanan st
(If rural, give LOCATION)
2.(a) If veteran, name war: world war #1.

3.(a) FULL NAME MAXWELL FERGAS STRUNK

3.(b) Social Security Number /

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Lillian Strunk
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): March 6, 1896

8. AGE: Years: 50 Months: 11 Days: 0 If less than one day: ..... hrs. ..... min.

9. Birthplace: Penna (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Inter state Commerce Comm,

FATHER
12. Name: samuel strunk
13. Birthplace: Holland

MOTHER
14. Maiden name: Isabella Fergas
15. Birthplace: scotland

16. Informant: Maxwell Fergas Strunk
Address: 4700 woodbury Rd - Riverdale Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: March 5, 1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: near Colmar Manor Md.

18. Funeral director: J Gaschs sons
Address: Hyattsville Md.

19. Mar 5th 1947 (Date rec'd by registrar) Mrs Jas Revere (Registrar) Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 2 1947, at 8:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jany 1944, to Mar 2 1947
and that I last saw h[illegible] alive on Feb 26 1947

Immediate cause of death	DURATION
coronary occlusion	45 min
Due to: coronary thrombosis	4 years
Due to: arteriosclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry G Bradley M.D.
M. D. or other
Address: 125 [illegible] Date signed: Mar 2 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1-25

2-2450 —— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★B 03120

Reg. Diat. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs., 10 mos., 18 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium,

How long in hospital or institution? 5 yrs., 10 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 426 - 15th St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME BERTHA SWINBURN

3.(b) Social Security Number - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Leslie Swinburn

6.(c) If alive, give age - - years

7. Birth date of deceased (mo., day, yr.) July 21, 1907

8. AGE: Years	Months	Days	If less than one day
39	7	19	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: --

FATHER
12. Name: Joseph Buckler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Bertha Agnes Tippett
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. removal (Burial, cremation, or removal. Which?) Date thereof: Mar. 10, 1947 (month) (day) (year)

Cemetery or crematory:
Location: Galesville, Md.

18. Funeral director: T. A. Hardesty
Address: Galesville, Md.

19. Mar. 10 19 47 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10th 1947, at 2.15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 21st 1941, to March 10 1947 and that last saw her alive on March 10th 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 yrs 2 mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincus M.D.
M. D. or other
Address: Glenn Dale Md. Date signed 3/10/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2-2420 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03121

CB

Reg. Dist. No. 2431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 hours

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 14 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 23 Congress Ct., N. W. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SALLY TILLERY

3.(b) Social Security Number: - -

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	Colored	Separated

6.(b) Name of husband or wife: Willie Tillery

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): August 6, 1893

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
53	7	11		

9. Birthplace: Halifax, North Carolina (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: - -

FATHER — 12. Name: ? Wade

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: Frances Wade

MOTHER — 15. Birthplace: Halifax, North Carolina

16. Informant: Chest Clinic & Edward Tillery

Address: Brother, 23 Congress Ct., N. W.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar 18, 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D. C.

18. Funeral director: Wm. T. Tolbert

Address: 1308 - 6th St. N. W.

19. Mar 18 1947 Rowland S. Phillips (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1947, at 11 40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1947, to Mar. 17 1947 and that I last saw her alive on Mar. 17 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: Mar. 18, 1947

2-25

2-2430 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

★ 03122

Reg. Diat. No. 3450

1. PLACE OF DEATH:

County Prince George

City or town Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4411-30th St Mt Rainier Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Mt Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4411-30th St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Helen May Tobin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Andrew R.

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 1st 1902

8. AGE: Years	Months	Days	If less than one day
44	10	22	...hrs. ...min.

9. Birthplace Washington D. C.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Wm. H. [illegible]

13. Birthplace Washington D. C.

14. Maiden name Florence Mack

15. Birthplace Washington D.C.

16. Informant Andrew R. Tobin

Address 4411-30th St. Mt Rainier Md.

17. Burial Date thereof 3/26/1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ft Lincoln

Location Bladensburg Rd & D.C. Line Md.

18. Funeral director Edward J. Walker

Address 3200-R.I. Ave. Mt. Rainier Md.

19. March 25 1947 James Seney

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1947, at 1:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 26, 1946, to March 23, 1947

and that I last saw her alive on March 8— 1947

Immediate cause of death	DURATION
Metastatic Carcinoma	4 months
Due to Melanosarcoma of left eye	2 years
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Mt Rainier Md Date signed 3/25/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Coroner James D. Boyd, of Forestville, Md. - Coroner for Prince George County, has filed D. death and will approve this death certificate.

03123

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 2340

1. PLACE OF DEATH:
County: Prince Georges
City or town: Clinton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 49 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Clinton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Lucinda Tolson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Widowed

6.(b) Name of husband or wife: James T Tolson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12 - 1865

8. AGE: Years 82 | Months 8 | Days 18 | If less than one day: hrs. min.

9. Birthplace: Rosaryville Pr. Georges, Md
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Robert Wheeler
13. Birthplace: Symantsville, Md

MOTHER
14. Maiden name: Eliza Ann Carroll
15. Birthplace: Poplar Hill, Pg Geo Co. Md

16. Informant: William H. Steward
Address: Clinton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 2 1947 (month) (day) (year)
Cemetery or crematory: St. Johns
Location: Clinton, Md.

18. Funeral director: Arthur L. Rollins Funeral Home
Address: 4339 Hunt Pl. N.E. Wash D.C

19. Mar 31 1947 (Date rec'd by registrar) Mrs. Alton Davis Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1947 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944, to Mch 30 1947 and that I last saw h[illegible] alive on Mch 25 1947

	DURATION
Immediate cause of death: Chronic myocarditis	3 yrs
Due to: age	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

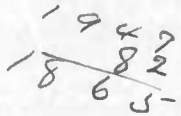
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John E. Bowers M.D. M. D. or other
Address: Brandywine, Md Date signed: 3/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-AT5 9-45-15M



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

U3124

Reg. Diat. No. 945 1

1. PLACE OF DEATH:

County: Prince George County

City or town: Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 1 1/2 mo.

Hospital, institution, or street address where death occurred:

Prince Leland Memorial Hosp.

How long in hospital or institution? 1 yr. 1 1/2 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 301 Longfellow St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME (Mr. James) Mr. Vincent Potarofila

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Antoinette Potarofila

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1868

8. AGE: Years	Months	Days	If less than one day
78	8	22	hrs. min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: not employed

11. Industry or business: ?

FATHER — 12. Name: ?

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace: ?

16. Informant: Josefie Harrison (daughter)

Address: 3900 Carlton ave Mt Rainier Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Mar 7/47 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Wash. D.C.

18. Funeral director: W.W. Chamberlin Co.

Address: 517 - 11 St N.E. D.C.

19. Mar 4th 1947 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-4 1947, at 6:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31 1946, to March 4 1947 and that I last saw h... alive on March 3. 1947

Immediate cause of death	DURATION
(a) Cardiac Insufficiency	1 day
Due to: Hypertensive Cardio-Vascular disease	1 yr+
Due to:	
Other conditions: Emphysema	15 mo
Due to Cerebral Hemorrhage	15 mo.

(Include pregnancy within 3 months of death)

Major findings of operation: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Walcott W. Linton MD (M. D. or other)

Address: Riverdale, Md Date signed: 3-4-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1-25

2-2450 ——— 1-19

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

03125

Reg. Diat. No. 2340

1. PLACE OF DEATH:
County: Prince Georges
City or town: Accaheek Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Accaheek, Md.
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Accaheek, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: none
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Benjamin Aloysius Underwood.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Ruth Bagot Underwood
6.(c) If alive, give age: 67 Yr. years

7. Birth date of deceased (mo., day, yr.): Dec -?- 1872

8. AGE:

Years	Months	Days	If less than one day
74	—	—	...hrs. ...min.

9. Birthplace: Accaheek Md.
(Town, county, and state) Prince Georges County

10. Usual occupation: Farmer

11. Industry or business: Owns farm

FATHER
12. Name: Isaac Underwood.
13. Birthplace: Maryland (Chas Co.)

MOTHER
14. Maiden name: Mary Farrell
15. Birthplace: Maryland.

16. Informant: Rosalee Smith
Address: Accaheek, Md

17. Burial, cremation, or removal. Which? Burial Date thereof 3-8-47 (month) (day) (year)
Cemetery or crematory: St Paul
Location: Accaheek Md

18. Funeral director: Hunt & Ryan
Address: Bowie Md

19. 3-7 1947 (Date rec'd by registrar) M. L. Mowes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1947 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1947, to March 6 1947
and that I last saw him alive on March 5 1947

Immediate cause of death: Typus Sarcoma — DURATION 4 mo.
Primary in lymph-glands of neck
Due to: Underlying cause
General enlargement of lymph-glandes
Due to:
Other conditions: General Arteno Sclerosis — Several Years
(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: no Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Paul C. Van Hatten M. D. or other
Address: Washington D.C. Date signed Mar 6 1947.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

CB 03126

Reg. Diat. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos., 14 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or Institution? 8 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 637 Maryland Avenue, N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SEGUNDO VELASCO

3.(b) Social Security Number: 577-16-8477

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Phillipine	Single

6.(b) Name of husband or wife: - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 29, 1906

8. AGE: Years	Months	Days	If less than one day
40	11	15	hrs. min.

9. Birthplace: Ahaloe, Phillipine Islands
(Town, county, and state)

10. Usual occupation: Butler (home)

11. Industry or business:

FATHER
12. Name: Fermin Velasco
13. Birthplace: - -

MOTHER
14. Maiden name: Victorina Presas
15. Birthplace: Phillipine Islands

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 15, 1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Prince George Co., Md.

18. Funeral director: W. W. Chambers Co.

Address: 517 - 11th St. S.E., Wash. D.C.

19. Mar 14, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 14, 1947, at 8.35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29, 1947, to Mar. 14, 1947 and that I last saw h... alive on Mar. 13, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs
Due to: Complications: -	
Tuberculosis of left 1st	
Due to: Metatarsal bone with	
draining sinus	8 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glen Dale, Md. Date signed: Mar 14, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2-2130 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03127

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1311 Union St., S. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CHESTER J. VENNY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male (MALE)	Colored	Married

6.(b) Name of husband or wife: Ruth Venny

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): May 20, 1899

8. AGE: Years	Months	Days	If less than one day
47 47	10	6	....hrs. ....min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Guard

11. Industry or business: Federal Works

FATHER
12. Name: Samuel Venny
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary Jordon
15. Birthplace: ? Virginia

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar. 27, 1947 (month) (day) (year)

Cemetery or crematory

Location: to Washington, D.C

18. Funeral director: Eugene Ford

Address: 1213 4th St S.W. Wash. 4 D C

19. Mar. 26, 1947 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 26, 1947, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 21, 1947, to Mar. 26, 1947

and that I last saw h.. alive on Mar. 26, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	7 yrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: Mar 26, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430-2-10

Evidence for change of age is shown on Film D.109 - 3/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

03128

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince Georges
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 years
Hospital, institution, or street address where death occurred: 200 feet North of Station on West side of track
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
Street No. 42 A Street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Wynnbert W. Walsh
3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Elaine W. Walsh
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): July 19, 1908
8. AGE: Years √38 ~~39~~ Months 7 Days 22 If less than one day ... hrs. ... min.
9. Birthplace: Landover, Md. (Town, county, and state)
10. Usual occupation: Warehouseman
11. Industry or business: Peoples Drug Store
FATHER 12. Name: Joseph Walsh
13. Birthplace: Washington, D.C.
MOTHER 14. Maiden name: Eva Hopkins
15. Birthplace: Laurel, Md.
16. Informant: Mrs Margaret Williams
Address: Laurel, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 14, 1947 (month) (day) (year)
Cemetery or crematory: Ivy Hill
Location: Laurel, Md.
18. Funeral director: Albert Donaldson
Address: Laurel, Md.
Mar 13 1947 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1947, at 6:05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...
Immediate cause of death: Hemorrhage and shock
Due to: Crushed skull
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
DURATION
Major findings of operations:
Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 3-11-47
Where did injury occur? Laurel (City or town) P. G. (County) Md (State)
Injured at home, farm, industry, public place (where?) B and O track
Means of injury: Pedestrian Struck by train Injured at work? No
Deputy Medical Examiner
23. SIGNATURE: James I. Boyd M. D. or other
Address: Forestville Md Date signed: 3-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

I-35

Evidence for change of age & birth date is shown on Film D109-3126/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

03129

Reg. Dist. No. 2421

1. PLACE OF DEATH:

County Prince George's

City or town Aquasheela

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Aquasheela

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Thomas Washington

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1906

8. AGE: Years	Months	Days	If less than one day
40	6		hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Henry Washington

13. Birthplace Maryland

MOTHER 14. Maiden name Laura Glasco

15. Birthplace Virginia

16. Informant Rebecca Mathis

Address 505 N. St NW, Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-11-47 (month) (day) (year)

Cemetery or crematory Metropolitan AME Church Cem.

Location Bowie, Maryland

18. Funeral director John T. Plummer & Co

Address 901-3 St. S.W.

19. March 9 1947 (Date rec'd by registrar) Thos F. Flutt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Convulsions	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Means of injury

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Forestville Md Date signed 3-8-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-25

2-2420 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

CERTIFICATE OF DEATH

03130

★ Reg. Dist. No. 2451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Berwyn

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stewart's Cottages

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. Edward Forest Watson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 19, 1886

8. AGE:

Years	Months	Days	If less than one day
61	0	22	hrs. min.

9. Birthplace: ? Penna. (Town, county, and state)

10. Usual occupation: Short order cook

11. Industry or business: Stewart's Restaurant

FATHER 12. Name: Blair Otto Watson

FATHER 13. Birthplace: ? Penna.

MOTHER 14. Maiden name: Mary Matilda Clark

MOTHER 15. Birthplace: ? Penna

16. Informant: Leland Memorial Hospital Record

Address: Riverdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 17, 1947 (month), (day), (year)

Cemetery or crematory: Arlington Cemetery

Location: Arlington Va.

18. Funeral director: E Edes & sons

Address: Hyattsville Md

19. March 15, 1947 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 1947, at 3 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-10, 1947, to March 13, 1947, and that I last saw him alive on 3-12, 1947

	DURATION
Immediate cause of death: Uremia myocarditis	5 yr
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Truman Hay, M. D. or other

Address: Hyatts. Md Date signed: 3-13-47

1-25

2-2450 —— 1-10

03131

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (147)

CERTIFICATE OF DEATH

Reg. Dist. No. 2310

1. PLACE OF DEATH
County: Prince Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Sheriff Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Emanuel White

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Grace Briggs
6.(c) If alive, give age: [illegible] years

7. Birth date of deceased (mo., day, yr.): Feb 12, 1914

8. AGE: Years	Months	Days	If less than one day
33			...hrs. ...min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Labour—
11. Industry or business: Cement Block Co.
FATHER 12. Name: John White
FATHER 13. Birthplace: Md
MOTHER 14. Maiden name: Emma Henson
MOTHER 15. Birthplace: Md
16. Informant: Mary Parker
Address: Lusby Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar 18 1947 (month) (day) (year)
Cemetery or crematory: Washington Funeral Home
Location: Washington, D. C.
18. Funeral director: F. Gaeaber Sons
Address: Bladensburg Md
19. 3/18 1947 (Date rec'd by registrar) Amanda Deuney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1947, at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death: Pneumonia and shock	
Due to: Incised Wound of Neck	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 3-15-47
Where did injury occur? Hyattsville (City or town) P.G. (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Cut during an altercation (Specify whether accident, suicide, or homicide)

23. SIGNATURE: [illegible] Deputy medical Examiner M. D. or other
Address: Hyattsville Md Date signed: 3-15-47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-C)

CERTIFICATE OF DEATH

03132

Reg. Diat. No. 2457

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/2 hours

Hospital, Institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4010 Ingraham

(If rural, give LOCATION)

2.(a) If veteran, name war No.

3. (a) FULL NAME William Whiteford

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1929

8. AGE: Years	Months	Days	If less than one day
17	3	8	..... hrs. ..... min.

8. Birthplace Martinsberg W. Va

(Town, county, and state)

10. Usual occupation Student

11. Industry or business University of Maryland

FATHER

12. Name F. Clay Whiteford

13. Birthplace Whiteford, Md

MOTHER

14. Maiden name Isabelle Smith

15. Birthplace Philadelphia, Pa

16. Informant Mrs. Isabelle Whiteford

Address 4010 Ingraham St Hyattsville Md

17. Burial Date thereof March 10, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Statesville Churchyard

Location Lilta Pa

18. Funeral director F Grechi sons

Address Hyattsville Md.

19. March 10 19 47 Mrs. Jas. Devere

(Date rec'd by registrar) Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 19 47, at 3 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Hemorrhage and Shock	
Due to fracture of base of skull	
Due to	
Other conditions Compound comminuted fracture of left leg	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3-8-47

Where did injury occur? Hyattsville Pr. G. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Baltimore and College Park

Means of injury Pedestrian struck by car Injured at work? No

(Deputy medical Examiner)

23. SIGNATURE ..... M. D. or other

Address Hyattsville Md Date signed 3-8-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as to age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-2450 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03133

CERTIFICATE OF DEATH

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince Georges
City or town: Bladensburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 years
Hospital, institution, or street address where death occurred: 3901 - 52nd Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Bladensburg (If outside city or town limits, write RURAL and give nearest town)
Street No. 3901 - 52nd Street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Warren Edward Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): February 24, 1923

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
24				

9. Birthplace: District of Columbia (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business

FATHER
12. Name: Frederick G. Williams
13. Birthplace: Canada

MOTHER
14. Maiden name: Anna G. Olmeyer
15. Birthplace: Washington D.C.

16. Informant: Frederick G. Williams
Address: 3901 - 52nd Street

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 7, 1947 (month) (day) (year)
Cemetery or crematory: Hyeong Funeral Home
Location: 13th & R Sts. N.W. Washington D.C.

18. Funeral director: F. Gaeth's sons
Address: Hyattsville Md.

19. 3/9 19 47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 19 47, at 5-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Myocardosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other
Address: Hyattsville Md. Date signed: 3-7-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

cB 03134

Reg. Dist. No. 2310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Pr. Georges Co. Hospital
City or town: Pr. Georges Co., Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1817 Kearney St. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HELEN WILLIAMSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Married

6.(b) Name of husband or wife: Dunbar C. Williamson
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
50 49			hrs. min.

9. Birthplace: Wash. D.C. (Town, county, and state)
10. Usual occupation: School Teacher
11. Industry or business
FATHER 12. Name: Herman Bein Kraar
13. Birthplace: Md
MOTHER 14. Maiden name: Minnie Gillies
15. Birthplace: Md
16. Informant: Dunbar Williamson
Address: 1817 Kearney St N.E.
17. Burial, cremation, or removal. Which? Burial Date thereof: March 24/47 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery.
Location: Washington, D. C.
16. Funeral director: S. H. Hines Co.,
Address: 2901 14th St., N.W. D.C.
19. 3/22 1947 (Date rec'd by registrar) Amanda Dewey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/21 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1938, to 3/21 1947
and that I last saw h er alive on 3/21 1947

Immediate cause of death	DURATION
Hypostatic pneumonia	72 hrs.
Due to: Carcinomatosis Generalized - from	8 years
Due to: left breast -	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: amputation of left breast - wide resection. Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A H Heath M. D. or other
Address: 1833 - Monroe St. Date signed: 3/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03135

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 19 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1yr., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 811 Dixon Court, S. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: JULIA, WIMBUSH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Clifford Wimbush
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1909

8. AGE: Years	Months	Days	If less than one day
37	6	12	...hrs. ...min.

9. Birthplace: Brandy, Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: - -

FATHER
12. Name: Thomas Thompson
13. Birthplace: Brandy, Virginia

MOTHER
14. Maiden name: Fannie Thompson,
15. Birthplace: Brandy, Virginia

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Mar. 31, 1947 (month) (day) (year)
Cemetery or crematory
Location To Wash. D.C.
18. Funeral director: R T Horton
Address 1322 you st nw Wash DC

19. Mar 30, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30th 1947, at 12 50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 10th 1947, to March 30 1947
and that I last saw h.. alive on March 30th 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincare M.D. M. D. or other
Address: Glenn Dale Md. Date signed: Mar 30, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03136

Reg. Dist. No. 2310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince George's
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address (if not in hospital): Prince George Gen'l. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Upper Marlboro, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Crain Highway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah C. Wise

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Ulysses S. Wise

7. Birth date of deceased (mo., day, yr.): ?

6.(c) If alive, give age: 77 years

8. AGE: Years: 77 Months: Days: If less than one day: hrs. min.

9. Birthplace: Hagerstown Md.
(Town, county, and state)

10. Usual occupation: At home

11. Industry or business:

12. FATHER Name: Ephraim Keyser

13. Birthplace: Gettysburg, Pa.

14. MOTHER Maiden name: Catharine Steiman

15. Birthplace: Hagerstown, Md.

16. Informant: Mrs. E. O. Fellows

Address: Maryland Park, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 3-24-47 (month) (day) (year)

Cemetery or crematory: Congressional

Location: Washington, D. C.

18. Funeral director: Settle Bros.

Address: Upper Marlboro, Md.

19. 3/23 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1947, at 6:35 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1947, to Mar 22 1947 and that I last saw h[illegible] alive on March 22 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	14 days
Due to: Hypertension Cardio-Vascular Renal Disease	10 yrs
Due to:	
Other conditions: Arteriosclerosis	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James F. Isaacs M. D. or other

Address: Upper Marlboro, Md. Date signed: 3-23-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

03137

Reg. Dist. No. 245

1. PLACE OF DEATH: Pro Geo county
County ...
City or town Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, institution, or street address where death occurred:
...
How long in hospital or institution? ...

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ... County Pro Geo Co.
City or town Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4729 Baltimore Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME George G. Wiseman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Mabel Wiseman
6.(c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) March 21. 1886

8. AGE: Years	Months	Days	If less than one day
60	11	22	...hrs. ...min.

9. Birthplace Md (Town, county, and state)
10. Usual occupation Jailor
11. Industry or business Hyattsville Police
FATHER 12. Name Joseph Wiseman
13. Birthplace Md.
MOTHER 14. Maiden name Dorothy Hildebrandt
15. Birthplace Md
16. Informant Wm Wiseman
Address Hyattsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 18, 1947.
(month) (day) (year)
Cemetery or ~~Crematory~~ Evergreen Cemetery
Location Bladensburg Md
18. Funeral director J. Gaeths sons
Address Hyattsville Md.
19. March 18 1947 (Date rec'd by registrar) Mrs. Jas Devere Deputy, Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17. 1947 at 7.20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to Mar 17 1947
and that I last saw h... alive on Mar 15, 1947

Immediate cause of death	DURATION
Coma	
Type Pneumonia	over 1 year
Due to Cardio-Vascular Renal	
Due to ...	
Other conditions ...	

(Include pregnancy within 3 months of death)

Major findings of operations ...
Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Louis M. Jimeno M.D.
M. D. or other
Address Cottage City, Md. Date signed 3-18-47

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03138

Reg. Dist. No. 2-45

1. PLACE OF DEATH:
County Prince George
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 E. Crescent Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Frances Phyllis Zuccaro

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F-em.	White	married

6.(b) Name of husband or wife Anthony Alfred Zuccaro
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 1920

8. AGE: Years	Months	Days	If less than one day
26	6	9	hrs. min.

9. Birthplace Boston Mass.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Anthony Marino
13. Birthplace Italy
MOTHER 14. Maiden name Flonia Isella
15. Birthplace Boston Mass.
16. Informant Hospital record.
Address
17. Burial, cremation, or removal. Which? Buried Date thereof Mar. 22-47 (month) (day) (year)
Cemetery or crematory Holy Cross Cemetery
Location Boston, Mass
18. Funeral director W.D. Chambers Co.
Address Riverdale, Md.
19. March 20 1947 (Date rec'd by registrar) James Seay Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 19 1947, at 6:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947, to Mar 19 1947
and that I last saw h.. alive on Mar 19 1947

	DURATION
Immediate cause of death: Acute Cardiac Failure	
Due to: Postoperative Toxemia	5 hours
Wound Evisceration	3 hr.
Due to: Chronic Ulcerative Colitis	5 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Chronic Ulcerative Colitis with old abscesses. Date of op. Mar 10, 1947
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L W Malin M.D.
M. D. or other
Address Riverdale, Md. Date signed 3-19-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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